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Canada. Royal commission on health services.

Hearings. J. 11-13, 1961-62

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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

FREDERICTON

N. B.

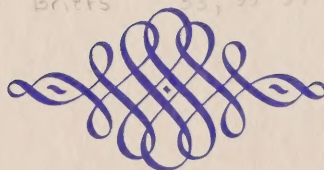
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NEW BRUNSWICK MEDICAL SOCIETY

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TORONTO, ONTARIO

1
2 ROYAL COMMISSION ON HEALTH SERVICES

3
4 Proceedings of the hearing
5 held in Fredericton, N.B.,
6 10th day of November, 1961.

7
8 COMMISSION MEMBERS:

9 CHIEF JUSTICE EMMETT M. HALL ----- Chairman

10 MISS ALICE GIRARD, R.N.

11 DR. DAVID M. BALTZAN

12 PROF. O. J. FIRESTONE

13 MR. M. WALLACE McCUTCHEON, Q.C.

14 DR. C. L. STRACHAN

15 DR. ARTHUR F. VAN WART

16
17 COMMISSION COUNSEL:

18 MR. R. N. HALL, Q.C.

19
20 MEDICAL CONSULTANT:

21 DR. PIERRE JOBIN

22
23 DIRECTOR OF RESEARCH:

24 PROF. BERNARD BLISHEN

25
26 SECRETARY:

27 MAJ. N. LAFRANCE
28
29
30

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and in ...
1988 ...

CHINA JUSTICE BUREAU ...

PROF. OF ...

DR. C. L. ...

DR. ...

CONSTITUTION

... ...

REPUBLIC

... ...



Fredericton, N.B.,
Friday,
November 10, 1961.

--- On commencing at 9.00 a.m.

THE CHAIRMAN: We have received the
submission by the New Brunswick Medical Society in co-
operation with the Medical Council of New Brunswick.
Dr. Whitehead?

SUBMISSION

of

THE NEW BRUNSWICK MEDICAL SOCIETY

--- EXHIBIT NO. 43: Submission of the
New Brunswick Medical
Society.

APPEARANCES:

DR. T. S. DOUGAN,

DR. PHILIP d'ENTREMONT

DR. J. F. McINERNEY

DR. H. H. MacKINNON

DR. F. L. WHITEHEAD

DR. E. STILES

DR. H. P. MELANSON

DR. S. D. CLARK

DR. J. R. NUGENT

MR. WHITEHEAD: Mr. Chairman, members
of the Royal Commission on Health Services, I am Dr. F.
L. Whitehead, Secretary of the New Brunswick Medical
Society. My group has designated me to present this
brief to you, sir. May I first introduce the group who
are here with us this morning?



On commencing at 2.00 a.m.

THE CHAIRMAN: We have received the

submission by the New Brunswick Medical Society in con-

nection with the Medical Council of New Brunswick.

Dr. Williams

of

THE NEW BRUNSWICK MEDICAL SOCIETY

Submission of the
New Brunswick Medical
Society.

EXHIBIT NO. 13

APPEARANCES:

DR. T. S. DOUGAN,

DR. PHILIP D'ENTREMONT

DR. J. F. McINERNEY

DR. H. H. MACKINNON

DR. R. L. WHITEHEAD

DR. E. STILES

DR. H. F. MELANSON

DR. S. D. CLARK

DR. J. B. BROWN

THE CHAIRMAN: The following gentlemen have appeared in support of the submission of the New Brunswick Medical Society, and have been sworn in as members of the Medical Council of New Brunswick.



1 On my far left, Dr. Esmond Stiles
2 of St. Stephen, who is president of the New Brunswick
3 Medical Society. Then behind him is Dr. S. D. Clark,
4 Lancaster, President of the Medical Council of New
5 Brunswick. Dr. Nugent of Saint John, Registrar of the
6 Medical Council. The group here are those involved
7 in the preparation of the brief. Dr. Melanson of Moncton,
8 Dr. McInerney of Fredericton, Dr. Hector MacKinnon of
9 Fredericton, Dr. Philip d'Entremont of Moncton, and
10 Dr. T. S. Dougan of Sussex.

11 Sir, in planning this brief after
12 the terms of reference of the Royal Commission were
13 available to us in June, we felt that in this province,
14 which is not too big, it would be desirable for us
15 to pursue a line of attack, and we invited and
16 encouraged our sponsored plan, the Blue Shield, to
17 present their brief yesterday, and also the Department
18 of Health, which they submitted themselves, and it was
19 decided at our annual meeting early in September that
20 this submission would be made jointly by the Medical
21 Society and the Medical Council, the registration and
22 licensing body. We have tried, sir, to follow the
23 terms of reference as well as we could, and the format
24 of the brief is following that principle, and as the
25 situation, particularly the present situation, existing
26 situation in the fields of medical care and other
27 things was dealt with by other groups, our brief appears
28 to be relatively short.

29 I would like to say also, sir,
30 that this brief, while put together by this group, was

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of St. Stephen, who is president of the New Brunswick Medical Society. Then behind him is Dr. S. D. Clark,

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situation, particularly the present situation, existing

situation in the field of medical care and other

to be relatively short.

I would like to say also, sir,

that this brief, while put together by this group, was



1 presented in detail to our executive on October 5th,
2 and was approved by them.

3 We hope, sir, this will be of value
4 and help to the Royal Commission in its work, and we
5 should like to say even if it isn't, it has been a
6 tremendous help to us in understanding our own situation,
7 the work involved in preparing it.

8 1. The New Brunswick Medical Society,
9 Canadian Medical Association, New Brunswick Division,
10 in cooperation with the Medical Council of New Brunswick,
11 is pleased to submit the following brief to the Royal
12 Commission on Health Services in the hope that it will
13 assist the Royal Commission to understand the existing
14 situation on Medical Care for the population of this
15 province and to arrive at opinions and recommendations
16 for the future.

17 2. The New Brunswick Medical Society is
18 established under the Medical Act of New Brunswick,
19 includes all doctors who are registered and licensed
20 under the provisions of that Act, and has a total member-
21 ship of 486 doctors as of October 1st, 1961. The primary
22 object of our Society is "the advancement of medical
23 science in all its branches, the promotion of health,
24 and the improvement of medical services."

25 3. The members of The New Brunswick
26 Medical Society, by common agreement, became a Division
27 of The Canadian Medical Association in 1933. As a
28 Division and component part of The Canadian Medical
29 Association, we have adopted the "Statement on Medical
30 Services Insurance" June 1960 of the Canadian Medical

used in detail to our executive on October 5th.

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and the improvement of medical services."

3. The members of The New Brunswick

Medical Society, by common agreement, became a Division

of The Canadian Medical Association in 1953. As a

Division and component part of The Canadian Medical

Association, we have adopted the "Statement on Medical

Practice" which was adopted by the Canadian Medical



1 Association, and we are aware of, and are associated
2 with, the submission "Some Characteristics of the Medical
3 Profession of Canada" which has been submitted by the
4 C. M. A. to the Royal Commission on September 27th, 1961.

5 We agree with the overall picture therein presented.

6 4. In answer to Term of Reference (a)

7 (a) "THE EXISTING FACILITIES AND METHODS FOR PROVIDING
8 PERSONAL HEALTH SERVICES INCLUDING PREVENTION,
9 DIAGNOSIS, TREATMENT AND REHABILITATION".

10 the present situation in the Province of New Brunswick
11 is as follows:

12 5. Registration, Licensing, etc. of Medical Practitioners
13 In New Brunswick

14 The following information, Paras.
15 6 - 19 is submitted by the Medical Council of New
16 Brunswick.

17 6. The Medical Council of New Brunswick
18 is that instrument created by the laws of this Province
19 for the control of medical practice and medical practi-
20 tioners in this Province.

21 7. THE MEDICAL ACT.

22 The Medical Act was first written in
23 1877. This was a short form, recognizing those as medical
24 doctors who had had some form of formal medical education
25 or training. In 1881 an Act was passed "Re Registration
26 of Physicians and Surgeons" (1) defining the practice of
27 Medicine and Surgery, (2) incorporating a Council of
28 Physicians and Surgeons, (3) stating the requirements of
29 pre-medical education for registration as medical students,
30 (4) stating the requirements of medical education and



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Medicine and Surgery, (2) incorporating a Council of

Physicians and Surgeons, (3) stating the requirements of

pre-medical education for registration as medical students.

(4) stating the requirements of medical education and



1 other factors for registration as medical practitioners,
2 (5) empowering and directing the Council to enforce the
3 terms of The Medical Act and to investigate under oath
4 and take any punitive action fair and just in the case
5 of any practitioner alleged to have been guilty of mal-
6 practice or infamous, disgraceful or improper conduct.
7 This Act of 1881 was amended on several occasions until
8 in 1920 when it was re-written. In the new Act of 1920,
9 C52 10 George V 1920; the name was changed from Medical
10 Council of Physicians and Surgeons to the Medical Council
11 of New Brunswick and incorporated as such; the duties
12 and powers of Council were continued as under the previous
13 Act; the New Brunswick Medical Society was defined to
14 consist of all persons registered and licensed under this
15 Act and the membership of Council was laid down to consist
16 of nine member physicians, four of whom to be appointed
17 by Governor-in-Council and five to be elected by The
18 Medical Society. In 1958 the Medical Act "An Act
19 Respecting the Medical Profession" C.74 was assented to
20 May 1, 1958. This Act replaced former acts, incorporated
21 the Medical Society of New Brunswick and set down its
22 privileges and functions, continued the incorporation of
23 the Medical Council redefining its membership to consist
24 of ten physician members, nine of whom shall be elected
25 by the Medical Society on a staggered three-year term of
26 office and one to be appointed by the Minister of Health.
27 Note the change in basis of the selection of Councillors.

28 8. FUNCTIONS OF COUNCIL

29 The Council may make By-Laws under
30 The Act, not contrary to the law or the provisions of The



(5) empowering and directing the Council to enforce the terms of The Medical Act and to investigate under oath and take any punitive action fair and just in the case of any practitioner alleged to have been guilty of malpractice or infamous, disgraceful or improper conduct This Act of 1881 was amended on several occasions until in 1920 when it was re-written. In the new Act of 1920, C52 to George V 1920, the name was changed from Medical Council of Physicians and Surgeons to the Medical Council of New Brunswick and incorporated as such; the duties and powers of Council were continued as under the previous Act; the New Brunswick Medical Society was defined to consist of all persons registered and licensed under this Act and the membership of Council was laid down to consist of nine member physicians, four of whom to be appointed by Governor-in-Council and five to be elected by The

Respecting the Medical Profession" C.74 was assented to May 1, 1958. This Act replaced former acts, incorporating the Medical Society of New Brunswick and set down its privileges and functions, continued the incorporation of the Medical Council redefining its membership to consist of ten physician members, nine of whom shall be elected by the Governor-in-Council and one to be appointed by the Minister of Health.

The Council may make by-laws under The Act, not contrary to the law or the provisions of the



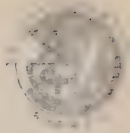
1 Act, concerning the registration and licensing of members
2 of the Society; the maintenance of a Specialists
3 Register; the registration of medical Students; the
4 educational requirements of medical students and all other
5 applicants for membership in the Society; and the
6 disciplinary supervision of all those registered and
7 licensed under The Medical Act.

8 9. REGISTRATION AND LICENSING:

9 The Medical Council of New Brunswick
10 has not conducted examinations for license since 1939
11 when the Council by By-Law decided to accept the Licenciate
12 examination of the Medical Council of Canada as its
13 requirement for registration. These examinations have
14 proven to be satisfactory and of great value in establish-
15 ing a uniform standard. No change in this regulation is
16 contemplated. No idea that the Province of New Brunswick
17 would, or should, ever forego its right to control its
18 own Medical Register has ever been entertained. The
19 examinationf of the Medical Council of Canada are open to
20 those who are the holders of an Enabling Certificate
21 issued by any one Provincial authority. Any person who
22 produces a licenciate certificate under the hand of the
23 Registrar of the Medical Council of Canada that he has
24 passed their examination, satisfied this Council as to his
25 identity and that he is of good character, and pays the
26 prescribed fee, is entitled to be registered.

27 (Page 5, Section 7, Subsection (1), paragraphs (e),
28 (f), (g), (h), The Medical Act 1958.)

29 10. SPECIAL REGISTRATION (Section 16, The Medical Act)



1 Act, concerning the registration and licensing of members
2 of the Society; the maintenance of a Specialists
3 Register; the registration of medical students; the
4 educational requirements of medical students and all other
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23 Registrar of the Medical Council of Canada that he has
24 passed their examination, satisfied this Council as to his
25 identity and that he is of good character, and pays the
26 prescribed fee, is entitled to be registered.

27 (Page 2, Section 7, Subsection (1), paragraph (a).)

28 10. SPECIAL REGISTRATION (Section 16, The Medical Act)

29 By request from The Hon. the Minister



1 of Health, and such information as is required concerning
2 the applicant's identity, character, previous good
3 standing and professional qualifications, the Council may
4 register the name of any physician employed on a full-
5 time basis in the public service of the Province. This
6 registration is cancelled if and when the registrant
7 leaves the public service. This registration does not
8 allow any privileges to private practice.

9 11. MEDICAL SPECIALISTS REGISTER

10 Any registered physician in New
11 Brunswick who applies for registration on the Specialists
12 Register and who possesses the credentials of Fellowship
13 in the Royal College of Canada, or who is certified as a
14 Specialist by the Royal College of Canada shall be placed
15 automatically, on application, on this Register in the
16 Specialty in which he is credentialled.

17 12. REQUIREMENTS FOR ENABLING CERTIFICATES:

- 18 a) CANADIANS: Satisfactory premedical training, graduation
19 from a medical school approved as a class A
20 school by the Council, submission of proof
21 that he or she has served one year of approved
22 internship satisfactorily. The New Brunswick
23 Council as a matter of policy strives to avoid
24 the issue of an Enabling Certificate to a
25 resident of another Province mainly by referring
26 the applicant back to the Province in which he
27 resides. New Brunswick, applicants are
28 required to be registered as Students.

29 b) CITIZENS OF GREAT BRITAIN, EIRE, & U.S.A.:

30 As for Canadians. These are granted an

the applicant's identity, character, previous good standing and professional qualifications, the Council may register the name of any physician employed on a full-time basis in the public service of the Province. This registration is cancelled if and when the registrant leaves the public service. This registration does not allow any privileges to private practice.

11. MEDICAL SPECIALISTS REGISTER

Any registered physician in New Brunswick who applies for registration on the Specialists Register and who possesses the credentials of Fellowship in the Royal College of Canada, or who is certified as a Specialist by the Royal College of Canada shall be placed automatically, on application, on this Register in the Specialty in which he is credentialled.

12. REQUIREMENTS FOR ENABLING CERTIFICATES:

a) CANADIANS: Satisfactory premedical training, graduation

from a medical school approved as a class A school by the Council, submission of proof that he or she has served one year of approved internship satisfactorily. The New Brunswick Council as a matter of policy strives to avoid the issue of an Enabling Certificate to a resident of another Province mainly by referring the applicant back to the Province in which he resides. New Brunswick applicants are required to be registered as Students.

b) CITIZENS OF GREAT BRITAIN, IRE, & U.S.A.:

As for Canadians. These are granted an



1 Enabling Certificate on application, identity and education
2 being established.

3 c) OTHER NATIONALS:

4 Proof of a premedical and medical
5 training comparable to that received by our Canadian
6 Students; proof of identity; proof of ownership of
7 degrees and credentials; testimonial of good moral char-
8 acter; completion of two years of satisfactory internship
9 in Canada in a hospital or hospitals approved by this
10 Council. One of these two years must be served in New
11 Brunswick.

12 13. STUDENT REGISTRATION (Sec. 7, sub-section (1),
13 Para. (f), The Medical Act, 1958.)

14 A student register is maintained. All
15 so registered are processed as to age, moral character,
16 premedical training, and on registration are so inducted
17 into the medical profession for whatever guidance is
18 possible. On satisfactory completion of their medical
19 studies they are granted the Enabling Certificate without
20 question.

21 14. FOREIGN INTERN REGISTRATION

22 Under By-Law of Council adopted in
23 1960, an attempt is being made to register all graduates
24 of Foreign Medical Schools undertaking interne or
25 resident service in any of our hospitals. The Regulations
26 set down for such registration are proof of satisfactory
27 basic and medical education, character reference and proof
28 of ownership of degrees and credentials. The bearers
29 passport and immigration authority information is valuable
30 in this context. All such foreign graduates registered



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Proof of a premedical and medical

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of ownership of degrees and credentials. The persons

passport and immigration authority information is valuable



under these regulations are assured of being granted an Enabling Certificate after their internship requirements are satisfactorily completed.

15. FOREIGN MEDICAL GRADUATES

In considering medical personnel from schools other than Great Britain, Eire, and U.S.A., you will note that we require two years internship in Canada, one year of which must be spent in our New Brunswick Hospitals. We consider this to be a method whereby from personal contact in our hospitals we are enabled to form an estimate of the applicants' moral, social and ethical characteristics as well as an approximate idea of his general and professional education before permitting him, by the granting of an Enabling Certificate, to sit the Licenciate Examinations of the Medical Council of Canada. Although some of these foreign graduates who have become registered with this Council have remained with us, the greater portion of them have either moved on to other Provinces or have returned to their native lands.

16. MEDICAL COUNCIL DISCIPLINARY FUNCTIONS

Section 31, The Medical Act 1958, states that the Council may appoint three or more medical practitioners to act as a Board of Inquiry for the purpose of investigating any complaint made against a medical practitioner alleging malpractice or infamous, disgraceful or improper conduct, on the part of the Medical practitioner.

Section 31 (3), the Board shall have power to summon, swear and compel production of documents.

Section 31 (4-5), to levy and

under these regulations are assured of being granted an Enabling Certificate after their internship requirements are satisfactorily completed.

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Section 31 (3), the Board shall have

power to summon, swear and compel production of documents,

Section 31 (4-5), to levy and



1 apportion costs.

2 Section 31(7), shall report to Council
3 and where it find guilt shall recommend to reprimand, or
4 to strike from Register and revoke license, or to suspend
5 license for a fixed period.

6 Section 32, The Act provides for an
7 appeal to a Judge of the Supreme Court and for a petition
8 for reinstatement at the expiration of one year from date
9 of removal.

10 17. In view of the present condition of
11 the all-embracing type of medical care offered by the
12 medical practitioners of this province to all of our
13 people we are of the firm conviction that no consideration
14 be given to any suggestion that our standards at present
15 operative be lowered in any detail. We are satisfied
16 that the present system of operation under our Medical
17 Act of 1958 is satisfactory and as time goes on could be
18 subjected to amendments, as in the past, calculated to
19 enforce additional standards as required.

20 18. ENROLEMENT:

21 (a) General Register 486 (Of these 10 are registered under
22 Sec. 16 of The Medical Act, and 8
23 of these are trained psychiatrists
24 who have not yet completed regis-
25 tration on the Specialists
26 Register)

27

28

29

30



Department of Health

Section 31(7), shall report to Council

and where it find guilt shall recommend to reprimand, or to strike from Register and revoke license, or to suspend license for a fixed period.

Section 32, The Act provides for an appeal to a Judge of the Supreme Court and for a petition for reinstatement at the expiration of one year from date of removal.

In view of the present condition of

the State, it is suggested that the medical practitioners of this province to all of our people we are of the firm conviction that no consideration be given to any suggestion that our standards at present operative be lowered in any detail. We are satisfied that the present system of operation under our Medical Act of 1928 is satisfactory and as time goes on could be subjected to amendments, as in the past, calculated to enforce additional standards as required.

18. ENROLLMENT:

(a) General Register 486 (Of these 10 are registered under Sec. 16 of The Medical Act, and 2 of these are trained psychiatrists who have not yet completed registration on the Specialists Register)



1 (b) Specialists Register 191

2 MEDICINE

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4	Allergy - Dermatology	1
5	Dermatology	1
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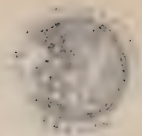
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MEDICINE

Internal

Allergy - Dermatology

Dermatology

Neurology

Pediatrics

Psychiatry

Public Health and Preventive
Medicine

SURGERY

General

Neurosurgery

Plastic Surgery

Thoracic Surgery

Orthopedic Surgery

Anesthesiology

Ophthalmology, Otolaryngology

Ophthalmology

Otolaryngology

OBSTETRICS

Obstetrics and Gynecology

Obstetrics

Chemical

PATHOLOGY

Diagnostic and Therapeutic

Diagnostic



19. Students Register 55

(Those to be graduated sometime during the coming
5-year period)

Attending University: Dalhousie Laval McGill Ottawa Foreign

27 8 11 4 5

Foreign Intern Register: Spanish Philippines Greeks Chinese

2 2 1 1

German

1

20. The supply of doctors in New Brunswick in relation to
population is:

Population 611,000 Total Number of Doctors 486

Overall Ratio - 1 : 1257

No. of G. P.'s - 294

No. of Doctors with
Specialist qualifications - 191 (40% of total)

It is thus shown that the number of
doctors per thousand of population is considerably less
than the National average of 1 : 888. The ratio ten
years ago, however, was 1 : 1530. Improvement in the
ratio has taken place in the natural course of events.
New Brunswick has no medical school and no research centres
and therefor practically all the doctors are engaged in
providing their services directly to the public, and
this factor should be taken into consideration when eval-
uating the overall ratio. It is, however, well known to
us that the supply of doctors in this province is not
adequate and that the shortage exists in some areas par-
ticularly. It is well known that there are a number of
communities which supported one, or even more, doctors a

(Those to be graduated sometime during the coming

Attending University: Delhousie Laval Medical Officer

Foreign Intern Registrar: Spanish Philippines Greek Chinese

German

population is:

Population 611,000

Total Number of Doctors 483

Overall Ratio

- 1 : 1257

No. of G. P.'s

- 234

No. of Doctors with

Specialist qualifications - 191 (40% of total)

It is thus shown that the number of

doctors per thousand of population is considerably less

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uating the overall ratio. It is, however, well known to

us that the supply of doctors in this province is not

adequate and that the shortage exists in some areas par-

ticularly. It is well known that there are a number of

communities which supported one, or even more, doctors a



1 generation ago, which today have no doctor resident in
2 the area. It is also known that in the last few years
3 doctors have left certain communities and so far no replace-
4 ment has settled there. There are many reasons involved
5 in these circumstances but probably the main ones are:

6 (a) Ease of transportation from the patient's point of
7 view, whereby the patient easily obtains his medical
8 attention from more distant points and does not
9 support the local physician.

10 (b) A doctor's desire to work in association with hospitals
11 in order to carry out the work he has been trained to
12 do.

13 (c) Low economic level of a particular area.

14 21. The evolution of specialism is quite
15 marked in this province which now has 40% of all its
16 doctors qualified as specialists in a certain field. These
17 men are formally recognized as having specialist qualifi-
18 cations by the Medical Council of New Brunswick under
19 provisions made in the Medical Act. The distribution of
20 specialist care has improved greatly in recent years.

21 22. PRIVATE PRACTICE

22 In the existing system of Private
23 Practice the factors of prevention, diagnosis, treatment
24 and rehabilitation are included and are supplied through
25 the direct relationship between the patient and the
26 physician. The patient chooses his doctor and the personal
27 relationship between patient and doctor is continuous.
28 (Certain aspects of prevention and rehabilitation will be
29 described more fully later).

30 23. Most practising doctors in this

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...the area. It is necessary to have a doctor

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ment has settled there. There are many reasons involved

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and rehabilitation are included and are supplied through

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physician. The patient chooses his doctor and the persons

relationship between patient and doctor is continuous.

(Certain aspects of prevention and rehabilitation will be

Most practising doctors in this



1 province continue to practice as individuals. There are
2 some Groups of doctors associated together, but the in-
3 dividual continues to function under a direct patient-
4 physician relationship.

5 24. The services of Specialists are
6 obtained by the patient to a large extent by direct access
7 to the Specialist. When services of specialist are
8 required on a consulting basis, these are obtained through
9 referral by the attending physician with the knowledge and
10 consent of the patient concerned.

11 25. It is thus seen that the patient in
12 this province has the freedom of choosing and changing his
13 medical attendant, that the doctor is free to choose the
14 type and location of his practice, and that the direct
15 personal responsibility and interest of the physician to
16 his patient is a very active factor.

17 26. In the province of New Brunswick the
18 vast majority of doctors' services to the public are
19 provided under Private Practice, the main exceptions being
20 those services provided directly by Government Departments,
21 e.g. in-hospital care for tuberculosis and mental illness.
22 Certain organizations make arrangements for specific
23 Groups of persons, under specific conditions of eligibility,
24 but the actual rendering of the service by the doctor is
25 by private practice on a fee for service basis.

26 27. The doctors of New Brunswick have
27 long been interested and active in the development of the
28 provision of Medical Care for organized groups of persons.
29 The following are the major organizations concerned, and
30 it should be noted that they, of themselves, provide only



province continue to practice as individuals. There are

individual continues to function under a direct patient-

physician relationship.

24. The services of specialists are

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to the specialist. When services of specialist are

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Certain organizations make arrangements for special

groups of persons, under specific conditions of eligibility,

but the actual rendering of the service by the doctor is

by private practice on a fee for service basis

27. The doctors of New Brunswick have

long been interested and active in the development of the



1 a method under which the services of doctors are offered
2 to specific groups of the population:

3 28. Workmen's Compensation Board of N. B. - the following
4 information has been provided by the Workmen's Compensation
5 Board:

6 (a) Approximately 80% of the work force of this province
7 is covered under the Workmen's Compensation Act -
8 the majority of those not covered are individuals
9 who work in groups of less than three.

10 (b) A detailed account of the operations of the Workmen's
11 Compensation Board is available in their Annual
12 Reports.

13 (c) Every practising physician in the province at some
14 time does render some service to persons eligible
15 under the Compensation Act. These services are
16 provided under the private practice system, the
17 W. C. B. itself having in its employ only one doctor
18 in the capacity of medical director. The fees paid
19 for the services are agreed upon between the Medical
20 Society and the Board, and are revised from time to
21 time. The Medical Society maintains a W. C. B.
22 Buffer Committee which is available for advice on
23 any matter of dispute re fees, and there is also
24 a referee provision, and a privilege of Appeal by
25 the workman.

26 29. Department of Veteran's Affairs -
27 the following information has been provided by the Depart-
28 ment of Veterans' Affairs.

29 " The Department of Veterans' Affairs
30 provides treatment services at Lancaster Hospital to all



to specific groups of the population:

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any matter of dispute re fees, and there is also

a referee provision, and a privilege of Appeal by

the workman.

29. Department of Veterans' Affairs -

the following information has been provided by the Depart-

ment of Veterans' Affairs.

The Department of Veterans' Affairs

provides treatment services at Lancaster Hospital to all



1 persons eligible to receive treatment through the Depart-
2 ment. Those eligible to receive treatment through the
3 Department are:

- 4 (1) Veterans or other persons who have been awarded
5 pension by the Pension Commission for disabilities
6 incurred during service.
- 7 (2) Complete medical care for those veterans who have
8 been awarded War Veterans Allowance.
- 9 (3) Those veterans who qualify through service and
10 limited resources for treatment of a non-pensionable
11 disability at a charge, or no charge by the Depart-
12 ment.
- 13 (4) Members of the Royal Canadian Mounted Police.
- 14 (5) Members of the Armed Forces.
- 15 (6) Sick Mariners.
- 16 (7) Other persons referred to this Department by respon-
17 sible agencies.
- 18 (8) Domiciliary care to entitled veterans.

19 During the year 1960, Lancaster Hospital treated 3503
20 patients for a total of 79379 hospital days. These
21 figures do not include those patients retained in hospital
22 under Domiciliary Care. In addition to treating eligible
23 persons at Lancaster Hospital the Department also provides
24 medical care to eligible pensioners and War Veterans
25 Allowance recipients through a doctor-of-choice plan
26 throughout the province. The eligible veterans are
27 entitled to visit their doctor-of-choice in their local
28 area for all ordinary home and office treatment.
29 During the year 1960, 308 patients were hospitalized for
30 a period of 1938 days in local hospitals through the

persons eligible to receive treatment through the Depart-

(1) Veterans or other persons who have been awarded pension by the Pension Commission for disabilities incurred during service.

(2) Complete medical care for those veterans who have been awarded War Veterans Allowance.

(3) Those veterans who qualify through service and limited resources for treatment of a non-pensionable disability at a charge, or no charge by the Department.

(4) Members of the Royal Canadian Mounted Police.

(5) Members of the Armed Forces.

(6) Sick Mariners.

(7) Other persons referred to this Department by responsible agencies.

(8) Domiciliary care to entitled veterans.

During the year 1960, Lancaster Hospital treated 8703

patients for a total of 79372 hospital days. These

figures do not include those patients retained in hospital

under Domiciliary Care. In addition to treating eligible

persons at Lancaster Hospital the Department also provides

medical care to eligible pensioners and War Veterans

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area for all ordinary home and office treatment.

During the year 1960, 308 patients were hospitalized for

a period of 1938 days in local hospitals through the



1 province as the direct responsibility of the Department
2 of Veterans Affairs. Reviewing our records we feel that
3 at one time or another, in greater or less degree, every
4 practicing physician in this province has provided medical
5 services to patients eligible for treatment through the
6 Department of Veterans Affairs. The only doctors in the
7 province who do not participate in the doctor-of-choice
8 plan are those doctors practicing in the Saint John area.
9 All patients living within the metropolitan area are
10 expected to report directly to Lancaster Hospital for
11 their medical treatment. If a doctor practicing in this
12 area should be called to visit an eligible veteran the
13 Department will assume responsibility for payment of his
14 fee for this visit, if the patient is immediately admitted
15 to Lancaster Hospital upon his recommendation.
16 There are eleven fulltime salaried physicians on the staff
17 of Lancaster Hospital; five of these doctors are
18 certified specialists in various fields of medicine;
19 there are twenty-three parttime physicians on the staff
20 of Lancaster Hospital, of whom nineteen are certified
21 specialists in various fields of medicine. These doctors
22 are all engaged in private practice in the Saint John
23 area.
24 At the present time there are twelve physicians on the
25 intern staff at Lancaster Hospital. These are two resi-
26 dents, one in Medicine and one in Surgery; the others
27 are senior internes divided between Medical and Surgical
28 Services.
29 30. Maritime Hospital Service Association
30 (Blue Shield) - we understand that the Maritime Hospital

province as the direct responsibility of the Department of Veterans Affairs. Reviewing our records we feel that at one time or another, in greater or less degree, every practicing physician in this province has provided medical services to patients eligible for treatment through the Department of Veterans Affairs. The only doctors in the province who do not participate in the doctor-of-choice plan are those doctors practicing in the Saint John area. All patients living within the metropolitan area are expected to report directly to Lancaster Hospital for their medical treatment. If a doctor practicing in this area should be called to visit an eligible veteran the Department will assume responsibility for payment of his fee for this visit, if the patient is immediately admitted to Lancaster Hospital upon his recommendation. There are eleven fulltime salaried physicians on the staff of Lancaster Hospital; five of these doctors are certified specialists in various fields of medicine; there are twenty-three parttime physicians on the staff of Lancaster Hospital, of whom nineteen are certified specialists in various fields of medicine. These doctors are all engaged in private practice in the Saint John area. At the present time there are twelve physicians on the intern staff at Lancaster Hospital. These are two residents, one in Medicine and one in Surgery; the others are senior internes divided between Medical and Surgical Services.

30. Maritime Hospital Service Association (Blue Shield) - we understand that the Maritime Hospital



1 Service Association (Blue Shield) is submitting a separate
2 Brief to the Royal Commission which will give their
3 position in detail. For our purposes at this moment it
4 is sufficient to say that Maritime Blue Shield was granted
5 'Official Approval' by the New Brunswick Medical Society
6 in 1950, that this was renewed yearly until 1960 when
7 'Official Approval' was changed to 'Sponsorship', that
8 the Medical Society is represented on the Board of
9 Directors of Blue Shield, and that a very close relation-
10 ship exists between the two bodies.

11 31. Department of Health -

12 Relationship between the Society and
13 the Department of Health has been very close through the
14 years. Consultation between the Department and the
15 Society has always been held on any proposal under which
16 payment for the services of private practitioners is
17 being offered by the Government to the public. Probably
18 the best example is the evolution of the Cancer Program,
19 wherein, at each step, the approval and detail before
20 the announcement has been made to the public.

21 In those areas of medical care for
22 which the Department of Health is fully responsible,
23 e.g. Tuberculosis and Mental Disease, the doctors engaged
24 by the Department are full and active members of the
25 Medical Society, and act as consultants and advisers to
26 the doctors in private practice. Certain specialist
27 consulting services for these departments are provided
28 by doctors in private practice. The Brief submitted by
29 the Department of Health separately to the Royal Commis-
30 sion will describe in some detail the Department's work



position in detail. For our purposes at this moment it is sufficient to say that Maritime Blue Shield was granted 'Official Approval' by the New Brunswick Medical Society in 1950, that this was renewed yearly until 1960 when 'Official Approval' was changed to 'Sponsorship', that the Medical Society is represented on the Board of Directors of Blue Shield, and that a very close relationship exists between the two bodies.

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1 in specific fields.

2 The following summary, (Paras 32 - 40)
3 of the utilization of the National Health Grants, together
4 with a summary of the Health Services administered and
5 financed by the Provincial Government in this province,
6 has been prepared by the Department of Health, at our
7 request. It presents information on many aspects of
8 medical care provided by doctors in the employ of
9 Government and also by private practitioners.

10 We understand that a more detailed
11 statement will be presented in the Brief being submitted
12 by the Department of Health, and we would support the
13 recommendations contained therein, as minimal requirements.

14 32. The National Health Grants were
15 initiated by the Federal Government through its Department
16 of National Health and Welfare. The effective date was
17 April 1, 1948. The purpose of these grants was to provide
18 assistance to the various provincial governments in
19 extending existing health services and providing new
20 health services for the people of each province.

21 This report and its statistics cover
22 the fiscal year of 1960-61, that is a period from April 1,
23 1960 to March 31, 1961 for the Province of New Brunswick.
24 The figures provided are rounded to the nearest hundred.

25 33. NON MATCHING GRANTS

26 Expenditures from these grants are
27 claimed by the province one-hundred per cent up to the
28 maximum of the grant.

29 (a) Professional Training ----- \$85,500.00 Amount of Grant
30 Expenditure, \$71,000.00 --- Percent of Grant, 83%



The following summary, (Pages 22 - 40)

of the utilization of the National Health Grants, together with a summary of the Health Services administered and financed by the Provincial Government in this province, has been prepared by the Department of Health, at our request. It presents information on many aspects of medical care provided by doctors in the employ of Government and also by private practitioners.

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the fiscal year of 1960-61, that is a period from April 1, 1960 to March 31, 1961 for the Province of New Brunswick. The figures provided are rounded to the nearest hundred.

NON-MATERIAL GRANTS

Expenditures from these grants are claimed by the province one-hundred per cent up to the maximum of the grant.

(a) Professional Training ----- \$85,500.00 Amount of Grant
Expenditure, \$71,000.00 --- Percent of Grant, 82%



This expenditure was utilized in the training of personnel employed in active treatment general hospitals.

(b) Mental Health ----- \$312,800.00 Amount of Grant
Expenditure, \$312,800.00 -- Percent of Grant, 100%

The above is made up of \$42,000.00 for post-graduate training of mental health personnel. The remainder provided for the operation of four regional mental health clinics and the service in Psychology and Psychiatric Social Work at our two large mental hospitals in the province.

This grant provided 10% of the total cost of mental health services in New Brunswick.

(c) Tuberculosis Control ----- \$157,500.00 Amount of grant
Expenditure, \$157,500.00 -- Percent of Grant, 100%,

This expenditure provided anti-tuberculous drugs to the extent of \$29,000.00. The operation of ten diagnostic clinics and the control centre at \$34,000.00. The provision of a Regional Tuberculosis Consultant Service at \$14,000.00 and the remainder was used to provide a rehabilitation service in the four treatment institutions of the province.

(d) General Public Health ----- \$504,500.00 Amount of Grant

Expenditure, \$461,700.00 -- Percent of Grant, 91%

Training of public health personnel to the extent of \$73,000.00

Equipment for University School of Nursing, \$13,000.00.

Salaries and travel of public health nursing personnel, \$165,000.00.

Sanitation services, \$53,000.00.



1	
2	training of personnel in the operation of the
3	general hospitals.
4	(b) Mental Health ----- \$312,800.00 Amount of grant
5	
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25	Training of public health personnel to the extent of
26	
27	\$165,000.00.
28	Sanitation services, \$53,000.00.



1 Public health laboratory tests on milk and water,
2 \$17,000.00.

3 Consultant service to hospitals under the Hospital
4 Services Plan, \$38,000.00.

5 Poliomyelitis vaccine, \$23,000.00.

6 Glaucoma and Auditory Clinic, \$12,000.00.

7 Venereal Disease Control, \$13,000.00.

8 Laboratory Services, \$7,000.00.

9 Assistance to the Canadian Council on Hospital
10 Accreditation, \$1,000.00.

11 Paediatric Diagnostic and Therapeutic Clinics,
12 \$3,600.00.

13 The remainder was expended on several small items in
14 the public health field.

15 (3) Child and Maternal Health -- \$76,500.00 Amount of Grant
16 Expenditure, \$42,100.00----- Percent of Grant, 55%

17 This expenditure provided for the direction of the
18 program in the field of nutrition and health to the extent
19 of \$28,000.00. The training of a nutritionist \$1,000.00
20 and post-graduate training of professional personnel in
21 the field of child and maternal health to the extent of
22 \$13,000.00.

23 34. MATCHING GRANTS

24 Any claim from these grants requires
25 that an equal and matching expenditure be made by the
26 province.

27 (a) Hospital Construction ----- \$1,411,600.00

28 Expenditure, \$508,000.00 -- Percent of Grant, 36%

29 The amount of this Grant is made up
30 of two parts. One part of \$590,000.00 which is the grant



Public health laboratory tests on milk and water.

Consultant service to hospitals under the Hospital

Services Plan, \$38,000.00.

Poliomyelitis vaccine, \$23,000.00.

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(3) Child and Maternal Health -- \$46,500.00 Amount of Grant

Expenditure, \$42,100.00 --- Percent of Grant, 90%

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of \$28,000.00. The training of a nutritionist \$1,000.00

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the field of child and maternal health to the extent of

MATCHING GRANTS

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(a) Hospital Construction --- \$1,411,600.00

Expenditure, \$508,000.00 -- Percent of Grant, 36%

The amount of this Grant is made up

One part of \$500,000.00 which is the grant



1 for the year under review, while the remainder is money
2 revoted from previous years which is allotted to hospital
3 construction projects which are under construction but
4 which have not been completed.

5 (b) Cancer Control----- \$70,000.00 Amount of Grant
6 Expenditure, \$62,500.00 -- Percent of Grant, 89%

7 A portion of this amount to the extent
8 of \$12,500.00 was given to the National Cancer Institute
9 to assist in research. The remainder was utilized to
10 assist the province in providing diagnostic service for
11 cancer at six clinics, out-patient X-ray and biopsy
12 service, the service of consultants and all types of
13 radiotherapy on an out-patient basis.

14 Effective March 1, 1961, this service
15 has been extended to include the provision of medical,
16 surgical, anaesthetic and consultant fees for service on
17 all cases of proven malignant neoplasm, while such cases
18 are in-patients of approved active treatment general
19 hospitals. It is estimated the cancer control program will
20 now cost the province \$250,000.00 annually, half of which
21 will be claimed from the federal source under the grants
22 program.

23 35. PARTIALLY MATCHING GRANTS

24 Expenditures from these grants may
25 be claimed one hundred per cent for training and equipment,
26 while the service to individuals is on a matching basis.

27 (a) Medical Rehabilitation

28 & Crippled Children ----- \$95,000.00 Amount of Grant
29 Expenditure, \$77,500.00 -- Percent of Grant, 81%

30 Training of personnel was provided to

the year under review, while the remainder is money
voted from previous years which is allotted to hospital

construction projects which are under construction but

which have not been completed.

(b) Cancer Control-----\$70,000.00 Amount of Grant

Expenditure, \$62,500.00 -- Percent of Grant, 89%

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of \$12,500.00 was given to the National Cancer Institute

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program.

PARTIALLY MATCHING GRANTS

35.

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while the service to individuals is on a matching basis.

Expenditure, \$77,500.00 -- Percent of Grant, 89%

Training of personnel was provided to



1 the extent of \$12,500.00 and \$65,000.00 was claimed from
2 the grant to assist the province in providing rehabilita-
3 tion services to disabled individuals on a fee for service
4 basis, after physical and financial assessment of the
5 disabled persons.

6 36. Health Services Administered and
7 Financed by the Provincial Government.

8 (a) Public Health Services.

9 This includes six district medical
10 health officers, 4 qualified by D.P.H. and two registered
11 physicians in an acting capacity as well as related per-
12 sonnel, \$100,000.00; public health nursing service,
13 \$299,000; sanitation services \$67,000.00; public health
14 laboratory service \$61,000.00; dental health, \$36,000.00
15 and the district boards of health (municipal) \$166,000.00.

16 The above services are available to
17 all areas and all residents of the province.

18 (b) Mental health services in New Brunswick for the fiscal
19 year of 1960-61 (April 1, 1960 to March 31, 1961) were
20 provided at a cost of \$3,358,000.00.

21 Analysis of the costs indicate the following:

22 Ten per cent was provided from National Health Grants.

23 Four per cent was paid by municipalities on behalf
24 of patients.

25 Ten per cent was paid by patients on their own res-
26 ponsibility.

27 Seventy-six per cent was paid by the provincial govern-
28 ment.

29 In effect then ninety per cent of this cost was paid
30 from public funds.



1 The grant to assist the province in providing rehabilita-
2 tion services to disabled individuals on a fee for service
3 basis, after physical and financial assessment of the
4 disabled persons.
5
6 Health Services Administered and 36.
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18 (b) Mental health services in New Brunswick for the fiscal
19 year of 1960-61 (April 1, 1960 to March 31, 1961) were
20 provided at a cost of \$3,358,000.00.
21 Analysis of the costs indicate the following:
22 Ten per cent was provided from National Health Grants.
23 Four per cent was paid by municipalities on behalf
24 of patients.
25 Ten per cent was paid by patients on their own res-
26 ponsibility.
27 Seventy-six per cent was paid by the provincial govern-



1 The mental health services of the province are as
2 follows:

3 Four mental health clinics throughout the province.
4 Two mental hospitals and two psychiatric sections in
5 active treatment hospitals. Total rated bed capacity is
6 1378 beds. Total beds set up and occupied, 1922. Total
7 patient days of hospital care to the mentally ill for the
8 year under review were 684,488 days. There are 26
9 qualified medical doctors employed on full time salary
10 basis in providing this service.

11 (c) The health care in tuberculosis consisting of preven-
12 tion, diagnosis, treatment and rehabilitation was provided
13 at a cost of \$2,380,000.00.

14 Analysis of this cost indicates that slightly less
15 than 7% was claimed from National Health Grants and the
16 remainder of slightly over 93% was paid by the provincial
17 government. In other words, 100% of the cost of health
18 care in tuberculosis is paid from public funds.

19 The cost of prevention and diagnosis was \$94,000.00
20 while the cost of treatment and rehabilitation was
21 \$2,286,000.00. The major portion of the above cost was
22 for treatment in tuberculosis hospitals.

23 The diagnostic and treatment services were provided
24 by 14 qualified medical doctors working on a full time
25 salary basis.

26 There are 710 beds in the rated bed capacity of the
27 four tuberculosis hospitals of the province. The beds
28 occupied average 396 beds. The total hospital days care
29 given to patients in the year under review was 175,944
30 days.

Four mental health clinics throughout the province.

Two mental hospitals and two psychiatric sections in active treatment hospitals. Total rated bed capacity is 1378 beds. Total beds set up and occupied, 1922. Total patient days of hospital care to the mentally ill for the year under review were 684,488 days. There are 26 qualified medical doctors employed on full time salary

basis in providing this service.

(c) The health care in tuberculosis consisting of prevention, diagnosis, treatment and rehabilitation was provided at a cost of \$2,386,000.00.

Analysis of this cost indicates that slightly less than 7% was claimed from National Health Grants and the remainder of slightly over 93% was paid by the provincial government. In other words, 100% of the cost of health care in tuberculosis is paid from public funds.

The cost of prevention and diagnosis was \$24,000.00

while the cost of treatment and rehabilitation was \$2,286,000.00. The major portion of the above cost was

for treatment in tuberculosis hospitals.

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by 14 qualified medical doctors working on a full time

There are 710 beds in the rated bed capacity of the

four tuberculosis hospitals of the province. The beds

occupied average 396 beds. The total hospital days were

given to patients in the year under review was 178,944



1 (d) The cancer control program has recently been revised
2 and expanded effective March 1, 1961.

3 Previous to that date, the province was providing
4 a diagnostic service at six diagnostic clinics in the
5 province, uninsured laboratory and x-ray out-patient
6 diagnostic service, facilities for biopsy service and all
7 types of out-patient radiotherapy for cancer treatment.
8 Expansion of the program as of March 1, 1961 included
9 the provision of all professional medical, surgical,
10 anaesthetic and consultant fees on a fee for service basis
11 for all proven cases of malignant neoplasm for residents
12 of the province while in-patients of approved active
13 treatment general hospitals. It is estimated the cancer
14 control program with this extension of services will cost
15 an annual amount of \$250,000.00. This cost is being
16 provided on a sharing basis from National Health Grants
17 and Provincial Government funds.

18 (e) ALCOHOL & DRUG ADDICTION -- No special facilities
19 provided.

20 (f) The provincial laboratory service is provided to all
21 the province in five regions. There is one chief labor-
22 atory, four regional laboratories, and two branch labor-
23 atories. These laboratories provide all public health
24 laboratory service for the province, as well as the
25 clinical laboratory service for all hospitals of the
26 province with the exception of the DVA hospital at Lancaster.

27 This service is staffed, operated and financed by
28 the provincial government at a cost of \$736,500.00 in the
29 past year.

30 The professional medical service in laboratories

The professional medical service in laboratories

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Previous to that date, the province was providing



1 was provided by 12 qualified medical doctors on a full
2 time salary basis.

3 (g) The Department of Health maintains and provides the
4 cost of a biological service in the province. This
5 service distributes 23 separate and distinct biological
6 preparations through the main depot and 28 sub-depots
7 located throughout the province. All preparations are
8 available to the public health service without charge to
9 the individual, while the major portion of these prepara-
10 tions are also available to the private practising
11 physicians free of charge for use on their patients.

12 This service is provided at a cost of \$105,000.00 annually.

13 (h) The Venereal Disease Control Program is provided and
14 financed by the province. Prevention is carried out by
15 the compulsory reporting and examination of all contacts
16 as well as compulsory treatment of all positive cases
17 found. The treatment service is provided by a special
18 clinic in one large center where the medical clinician
19 received a clinic fee per hour for his services. Treat-
20 ment in other areas of the province is provided on a fee
21 for service basis for the attending physician. All drugs
22 and biologicals are provided free to the patient. This
23 also includes free laboratory service. The service was
24 provided during the year under review at a cost of
25 \$27,000.00 and 50% of this cost is claimed from National
26 Health Grants.

27 (i) The Medical Rehabilitation Program is financed by
28 the Provincial Government with assistance from the Federal
29 Government. This service provides medical, vocational
30 and job placement services. The medical aspect provides



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(h) The Venereal Disease Control Program is provided and

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1 medical assessment, medical and surgical care, anaesthetic
2 service and consultants, prosthetic appliances and other
3 medical aids and living allowances when the patient is
4 away from home to receive out-patient therapy.

5 All disabled people are subject to a physical and
6 financial assessment before being eligible for this
7 service.

8 The service was provided on a sharing principle with
9 the Federal Government with the exception of training
10 which was claimed 100% from National Health Grants.

11 Training of professional and technical personnel,
12 \$12,000.00.

13 Co-ordination of rehabilitation which provides a
14 Director and personnel for counselling service to the
15 disabled individuals, \$41,000.00.

16 Service to disabled individuals was provided to the
17 extent of \$137,000.00.

18 The professional medical service to individuals was
19 all provided by qualified medical doctors on a fee for
20 service basis.

21 37. HEALTH SERVICES ASSISTED BY PROVINCIAL GOVERNMENT

22 The blood transfusion service in
23 New Brunswick is provided by the Red Cross Transfusion
24 Service with financial assistance from the Department of
25 Health.

26 The assistance provided from provin-
27 cial funds for the year under review was \$40,000.00.

28 This expenditure was designed to assist the Red Cross in
29 the professional and technical costs incurred in collect-
30 ing and processing the blood for distribution.



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1 38. THE HOSPITAL AS AN ELEMENT OF MODERN MEDICAL CARE

2 (a) The active treatment hospitals in
3 New Brunswick in 1949 contained 1893 beds as a rated bed
4 capacity. In the same year there was 2,326 beds set up
5 and operating. These facilities provided approximately
6 1,046 hospital days per thousand of population or approx-
7 imately 554,000 total hospital days of care in active
8 treatment hospitals at a net operating cost of \$7,548,000.00.
9 This volume of care was far below the National average.

10 In the year of 1958 (Twelve month
11 period previous to the Hospital Service Plan) there was
12 a rated bed capacity of 2,790 beds. These facilities in
13 that year provided 762,000 hospital days of care or
14 1,288 hospital days per thousand of population at a net
15 operating cost of \$11,700,000.00.

16 The year of 1960 shows a rated bed
17 capacity of 3,094 beds with a total of beds set up as
18 3,275. These facilities provided 1,037,800 hospital days
19 of care or 1776 hospital days per thousand of population.
20 This hospital service was provided at a net operating
21 cost of \$18,320,000.00.

22 In addition, these hospital facilities
23 provided out-patient insured services to the extent of
24 \$308,600.00 to the people of New Brunswick.

25 The volume of hospital services now
26 being provided and received by the people of New Brunswick
27 compares very favourably with the National average and
28 indeed exceeds that provided by certain other provinces in,
29 Canada.

30 (b) There are no convalescent hospitals



REPORT ON THE WORK OF THE HOSPITAL SERVICE PLAN

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New Brunswick in 1949 contained 1893 beds as a rated bed

and operating. These facilities provided approximately

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This volume of care was far below the National average.

In the year of 1958 (Twelve months

period previous to the Hospital Service Plan) there was

that year provided 762,000 hospital days of care or

1,268 hospital days per thousand of population at a net

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being provided and received by the people of New Brunswick

compares very favourably with the National average and

indeed exceeds that provided by certain other provinces in

There are no convalescent hospitals



operating as such in the province at the present time.

The need for such facilities is evident in the province at the present time.

(c) There are no chronic hospitals as such with the exception of those provided for the treatment of mental disease and tuberculosis. The aspect of these facilities have been set forth in the foregoing sections.

(d) The facilities for diagnostic services in-patient are all provided under the Hospital Service Plan. Diagnostic services out-patient are provided in laboratory as an entitled service under the Hospital Service Plan with a few special exceptions. Consideration is now being given to the extension of out-patient diagnostic services in the field of radiology.

(e) Out-patient emergency service is provided for all accident cases under the Hospital Service Plan, if such cases report for the service within 48 hours of the accident. This includes the diagnostic and out-patient treatment aspect of the case.

(f) Special Treatment Facilities.

1. Nil. Cardio Vascular Units.

2. Therapeutic radiology is available at four hospital centres in New Brunswick. All therapeutic radiology in-patient is provided under the Hospital Service Plan, while therapeutic radiology out-patient for all cancer cases is provided without cost to the patient.

3. Radio-isotope service is now available at one large hospital centre in the province.

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3. Radio-isotope service is now

available at one large hospital centre in the province.



4. Rehabilitation services are provided in the main at two hospitals, with a moderate volume provided in other active treatment hospitals including the DVA Hospital. The Polio Clinic and Health Centre provides facilities for children with various disabilities and for adults with disabilities due to poliomyelitis. The Forest Hill Rehabilitation Centre provides facilities for adults with all types of disability.

The Polio Clinic and Health Centre has a rated bed capacity of 79 beds with a completely equipped service for all types of therapy relative to rehabilitation, as well as, extensive out-patient facilities in this service.

Forest Hill Rehabilitation Centre has a rated bed capacity of 20 beds with all modern facilities for therapy, as well as, extensive out-patient facilities in this service.

Both of the above institutions are approved and operate as active treatment hospitals under the Hospital Service Plan.

(g) The homes for the aged and nursing homes in New Brunswick both are licensed and approved under the Welfare Branch of the Department of Youth and Welfare.

There are 45 homes for the aged containing a rated bed capacity of 999 beds. It is to be noted that there is not an equitable distribution of these beds throughout the province. In fact certain areas of the province have no beds of this type to deliver this



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1 service of domiciliary care. Approximately 90% of the
2 occupants of these homes are receiving substantial assis-
3 tance from Federal, Provincial and Municipal sources
4 through the Social Assistance Act.

5 The nursing homes number 13 with a
6 rated capacity of 317 beds. These show a slightly better
7 distribution throughout the province than do the homes
8 for the aged.

9 Approximately 70% of the inmates of
10 nursing homes are receiving substantial assistance for
11 their care under the Social Assistance Act from the same
12 sources as those in homes for the aged.

13 39. Hospital Insurance and Diagnostic
14 Services Act.

15 (a) This service is provided on a Federal-
16 Provincial basis according to the well known formula
17 developed by the Department of National Health and Welfare
18 on which they based their offer of assistance to all the
19 provinces and territories of Canada.

20 The final offer of assistance from
21 the Government of Canada for the active treatment segment
22 of health care and diagnostic services as well as medical
23 care and home nursing care was made in February 1956.

24 The Hospital Service Plan was initi-
25 ated in New Brunswick effective July 1, 1959.

26 (b) 1. In the year previous to the operation
27 of the Hospital Service Plan, New Brunswick residents
28 received 1288 hospital days per thousand of population
29 at a net operating cost of \$11,700,000.00, while in the
30 year of 1960, the New Brunswick people under a plan,

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care and home nursing care was made in February 1960.

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duced in New Brunswick effective July 1, 1959.

(b) In the year previous to the operation

received 1238 hospital days per thousand of population

at a net operating cost of \$11,700,000.00, while in the

year of 1960, the New Brunswick people under a plan,



1 received 1776 hospital days per thousand of population
2 at a net operating cost of \$18,320,000.00.

3 From the above, it is to be noted
4 that the increase in volume of care under the plan was
5 36% over 1958, while the increase in operating cost under
6 the plan was 56% for the period under review.

7 The availability of beds of the active
8 treatment type now appears fairly adequate with the
9 exception of two hospital areas where the bed supply is
10 definitely not adequate. These areas are in the north-
11 east and southeast of the province. Steps are now being
12 taken to correct this deficiency in these areas.

13 Several small wood structures in the
14 province now being used as hospitals are badly in need
15 of replacement by fire resistant structures. This should
16 be done at the earliest possible date. There now appears
17 to be a definite need for the convalescent and chronic
18 type of hospital which would operate under the plan and
19 which would provide the basic type of hospital and treat-
20 ment services for these selected type of cases.

21 40. Drugs and Appliances.

22 The provision of drugs from public
23 funds for the year of 1960 has been analyzed as follows:

24 In active treatment hospitals \$957,120.00

25 In DVA Hospital, Lancaster 41,932.00

26 In Mental and Tuberculosis
27 Hospitals including biologicals 263,868.00

28 Total drug expenditure from
29 public funds \$1,262,920.00
30

operating cost of \$18,320,000.00.

the plan was 50% for the period under review.

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In Mental and Tuberculosis Hospitals including biologicals \$62,868.00

Total drug expenditures from public funds \$1,962,920.00



1 The source of these funds indicates
2 that approximately 60% of this expenditure was provided
3 as a provincial responsibility while the remaining 40%
4 was claimed under hospital services, or from National
5 Health Grants as well as a direct expenditure by DVA for
6 treatment services to veterans resident in New Brunswick.

7 All of these drugs were prescribed
8 by qualified medical doctors.

9 The provision of prosthetic appliances
10 to residents of New Brunswick was carried out in the
11 year of 1960 at a cost of \$49,910.00. All such appliances
12 provided were prescribed by qualified medical doctors.

13 41. Medico-Lay Organizations - A relatively
14 small volume of services of individual doctors is arranged
15 for by some of these organizations, e.g. The Co-ordinating
16 Council for the Handicapped, through which certain services
17 are provided to children and others. The Medical Society
18 has been active in the formation of most of these groups
19 and is represented on policy matters through representation
20 on governing boards and medical advisory committees.

21 42. Private Insurance Coverage and Co-
22 operative Farm Services: These groups are placed together
23 simply for convenience, and because the Medical Society
24 does not have any representation on their policy-making
25 bodies as has been described under the Maritime Blue
26 Shield. Many different offerings are made to the public
27 which are frequently confusing to the insured person
28 because he does not know what is covered under his policy.
29 There is a general tendency for an insured person to
30 assume that any policy he purchases covers him for all

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treatment services to veterans resident in New Brunswick.

15th Grants as well as a direct expenditure by IWA for

was claimed under hospital services, or from National

as a provincial responsibility while the remaining 40%

approximately 60% of this expenditure was provided



services. In practice and in general terms, the attending physician assists his patient to obtain whatever benefit is available under his contract, the direct contractual arrangement between patient and physician continuing.

43. It is interesting to tabulate the following services available in New Brunswick:

1. All persons are covered for in-hospital treatment of cancer, tuberculosis and mental disease.
2. Injured workmen are covered by W. C. B.
3. Eligible persons are covered by D. V. A.
4. 148,023 persons are covered by Blue Shield. (24.4% of population of N. B.)
5. 72,000 (estimated) persons covered by Private Insurance and Co-operative (? 12%)

44. The remainder of the population falls into two main groups -

- (a) those who are able and willing to pay their own way, and
- (b) a segment of the population who are, what is commonly called, medically indigent. This latter group is made up of those in the official Welfare categories, e.g. Mothers' Allowances, and those persons who are unable to pay for medical care all the time or part of the time.

There are a great many reasons for medical indigency, some persons are indigent for all elements of life; some persons only when the illness is serious and prolonged; some persons because of seasonal unemployment; some persons because of age; some persons

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unable to pay for medical care all the time or part

of the time.

There are a great many reasons for medical indigency.

Some persons are indigent for all elements of life;



1 simply by improvidence. At the present time, in
2 New Brunswick, for the medically indigent person,
3 each city, town and municipality has a different
4 method of determining indigency and for deciding
5 whether any payment can be made for doctors' services.
6 Some areas have organized hospital departments where
7 doctors' services are available at all times for
8 indigent persons, without charge to the patient.
9 In most areas, the individual doctor provides medical
10 attention to those groups of people, knows their
11 ability to pay, and provides his services either
12 free of charge or within the framework set up by
13 the municipality in which he lives. The New Bruns-
14 wick Medical Society has had this problem under
15 review for many years.
16 At the 1961 Annual Meeting of the New Brunswick
17 Medical Society the following Resolutions were
18 passed:

19 "THAT the N. B. Medical Society direct the
20 Economics Committee and the Sponsored Plan to
21 study and develop methods of instituting a
22 Plan whereby the Indigent Groups and Elderly
23 Persons of this province may have available
24 to them Prepaid Medical Care, in keeping with
25 the Statement of Policy of the C. M. A.

26 - and -

27 THAT should the Welfare authorities be in
28 agreement and will consider the payment of the
29 premium necessary, this Society is willing to
30 make a definite contribution in order to get



1 a Plan into effect under which Prepaid Medical
2 Care may be made available for Indigent Persons
3 and needy Elderly Citizens."

4 Statistics on Welfare Groups in New Brunswick

5 October, 1961)

6 Mothers' Allowance 2,142 Dependents

7 Social Assistance 27,443

8 Old Age Security 5,372

9 Disabled 1,926

10 Blind 676

11 37,559

12 Wards of Children's Aid 1,350 7,391

13 38,909

14 Estimated No. of Dependents 7,391

15 Total 46,300

16 The above figures have been provided to us by the Depart-
17 ment of Health and have been obtained from the appropriate
18 Government Departments. These are the official Welfare
19 Groups, and are administered provincially.

20 The numbers of persons who are medically indigent, but
21 who are not included in the official Welfare Groups, is
22 not accurately known to us. We are informed that an
23 estimate of the numbers is being made and will probably
24 be presented in the Brief of the Department of Health.

25 45. Para-Medical Personnel - There has been a great
26 increase in the demand for para-medical personnel in
27 recent years. It is known that the supply of many of
28 the categories in certain areas is deficient, but we have
29 not been able to review requirements for all categories
30 on a provincial basis.

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Groups, and are administered provincially.

Government Departments. These are the official Welfare

ment of Health and have been obtained from the appropriate

16 The above figures have been provided to us by the Depart-

Total 46,300

38,909

1,350

7,391

37,559

Blind

676

Disabled

1,926

Old Age Security

5,375

October, 1961)

Statistics on Welfare Groups in New Brunswick

and needy "Bridely Citizens."



46. General Comments on the Existing Situation.

- (a) The Medical profession is concerned with the total medical care of the total population, on a continuous basis, and has assumed and discharged this responsibility over the years.
- (b) The private practice of medicine is the backbone of the supplying of the services of doctors to the public of this province. The direct personal relationship between patient and doctor is the major point of contact, and the important factor of the doctor working for his patient directly is preserved.
- (c) The methods and extent of paying the doctor for his services vary considerably, and so, does the eligibility for and extent of comprehensiveness of the care offered. Whatever the methods offered, and to whatever degree short of complete coverage, the doctor must assume the gap between the offering and full medical attention.
- (d) We recognize a manpower shortage of doctors but would point out that the present manpower is utilized to much greater advantage under existing conditions of initiative and competition than would ever be the case under any system where freedom is controlled.
- (e) It would seem to us that, with certain exceptions, the supply of Specialist physicians is adequate but that there is a definite shortage of general practitioners in many areas and that consideration must be given to improving the conditions of general practice sufficiently to attract more good men into this field of work.

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the supply of specialist physicians is adequate

but that there is a definite shortage of general

practitioners in many areas and that consideration

must be given to improving the conditions of general

practice sufficiently to attract more good men into

this field of work.



(f) We would emphasize the many methods of ensuring quality of medical care - basic training, internship, hospital regulation, continuing post graduate study, the powers of the Medical Council, and the day to day major factor of competitive practice.

(g) It is our feeling that the people of this province who earn their own way like the medical care that they now receive and under existing methods, and that they are willing to pay for it, also that they are willing to pay their share for those persons who cannot earn their own way.

(h) We feel that the people want and demand insurance against the cost of being sick, and that this should be made available to them within the Principles of the C. M. A. Statement of Policy.

(i) We feel that the services and methods provided by the different organizations mentioned, which have been evolved over the years to meet specific circumstances, have assisted greatly in the provision of medical care to the groups they cover.

(j) We would stress that a change of method would not of itself, produce better medical care.

47. We shall now endeavour to set down the deficiencies which we believe to exist, in the existing facilities and methods:

(a) Inadequate chronic and convalescent beds and rehabilitation facilities, reducing the effectiveness of the acute bed accommodation, producing lengthy waiting lists and postponement of necessary treatment.

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- (b) Diagnostic services to out-patients should be included as insured services under the Hospital Care Plan.
- (c) Deficiency in facilities for transfer of sick people from their own area to the point where hospital and medical services for their particular condition can best be provided - road and air ambulance services should be improved.
- (d) There is a need for a definite program of Prepaid Medical Care Insurance for the medically indigent, and currently uninsurable groups of the population, and also for the provision of essential drugs.
- (e) Considerable study should be given to the social and general welfare of our elderly citizens, in addition to and distinct from the strictly medical care of these persons.
- (f) There is a need for a greater degree of supervision by Government or other regulatory body over the Medical Care Insurance being sold to the public.
- (g) There is a deficiency in the care of the mentally ill, and a need for accommodation and care for children who are mentally deficient or otherwise seriously handicapped.
- (h) There is a grave problem in this province in obtaining and holding adequate trained staff to carry out the programs in all divisions of the Department of Health.
- (i) There is a need for more General Practitioners in various parts of the province, and for certain Specialists in certain areas.

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(f) There is a need for more General Practitioners in various parts of the province, and for certain Specialists in certain areas.



(j) There is a need for a better supply of para-medical personnel in practically all categories.

(k) There is a need for a concerted attack on the problem of the prevention of traffic accidents.

48. In answer to Term of Reference (b)

(b) "METHODS OF IMPROVING SUCH EXISTING HEALTH SERVICES".

Our answer to this Term of Reference seems to be best included in Paragraph 49.

49. (c) "THE CORRELATION OF ANY NEW OR IMPROVED PROGRAM WITH EXISTING SERVICES WITH A VIEW TO PROVIDING IMPROVED HEALTH SERVICES."

(a) The deficiencies noted in regard to provision of convalescent beds, ambulance services, etc. should, in our view, be corrected by extensions to the existing Hospital Care program.

(b) The deficiency regarding Prepaid Insurance for indigent groups should be corrected by correlating a new offering by the existing Blue Shield organization, with the policy-making body made up of representatives of the Provincial Government, Municipalities, Medical Society and Blue Shield.

(c) The deficiency regarding Insurance Contracts should be corrected by correlation with the existing supervision of insurance by the Provincial Government or other regulatory body. Minimum standards and regulations for all contracts should be clearly defined.

(d) In our opinion, the deficiency in the care of the mentally ill requires comprehensive study with regard to

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1. Necessity of expansion of hospital facilities in
 - (a) Mental Hospitals
 - (b) Psychiatric Units in General Hospitals
 - (c) Institutions for the mentally deficient.
 2. The role of Community Health Care
 - (a) Family practice
 - (b) Specialist practice
 - (c) Mental Health Clinics
 - (d) Local Mental Health Societies
 3. Training and maintaining adequate trained personnel
 - (a) Psychiatrists
 - (b) Psychologists
 - (c) Psychiatric Social Workers.
 4. Promotion of research into basic causes of Mental Illness.
- (e) Comments on personnel are contained in Paragraph 50.
50. (d) "THE PRESENT AND FUTURE REQUIREMENTS OF PERSONNEL TO PROVIDE HEALTH SERVICES."
- (a) It is difficult to specify how many more doctors are actually required in this province, but it would seem that the overall ratio should be considerably improved over what it is now (1 : 1257). The number of doctors has increased each year for the past several years, and there are now more New Brunswick men pursuing the study of medicine than there have been at any time for many years. Even with these factors in mind, steps should be taken to increase the numbers of suitable candidates entering the medical schools. It is felt that more

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Even with these factors in mind, steps should be

taken to increase the numbers of suitable candidates

entering the medical schools. It is felt that more



1 scholarships and/or low interest loans should be
2 made available.

3 (b) We have mentioned that there is a need to attract
4 and hold more good general practitioners in certain
5 communities and, in general terms, it seems to us,
6 that the requirements for additional general
7 practitioners might be adequately met,

8 (1) If there were a good program of Medical Care
9 Insurance for the indigent groups. In areas
10 where these groups form a relatively large
11 proportion of the people, the doctor would
12 receive a better recompense for his work and
13 thus would probably be in a position to remain
14 in those areas for a longer time, and such
15 areas would continue to attract energetic young
16 men. It seems to us that a subsidy by Govern-
17 ment toward the cost of paying the premiums
18 would be a much better method than to subsidize
19 the community as such or to attempt to hire
20 doctors on a salary or per capita basis.

21 (2) The extension of hospital beds under the
22 Hospital Care Plan should include the provision
23 of smaller hospitals in strategically placed
24 areas, including facilities for the doctor's
25 office and the ancillary staff, which would
26 help to alleviate the bed situation in the
27 larger acute hospitals, play an important part
28 in supplying more doctors in those areas, and
29 provide an on-the-spot service to the public,
30 thereby reducing transportation requirements.



(c) The distribution of specialists in private practice has improved a great deal in the past five or six years, and a further improvement is anticipated because there are a significant number of doctors at present pursuing post-graduate study in different fields, and certainly some of these men will return to the province. There is a definite tendency for New Brunswick doctors to do general practise for a number of years before pursuing Specialty study. Before a doctor gives up General Practice and goes into Specialty study for a lengthy and costly period he has surveyed the situation carefully and obtained advice from many sources, and it is believed that the line of study being pursued is in keeping with the demand for Specialist Care.

(d) In regard to doctors in the employ of Government, there is a pressing problem in the supply of Specialist services in many categories. It would seem that the remuneration for Specialists in Government employ must be placed on a much more competitive basis with other provinces and countries.

(e) "METHODS OF PROVIDING ADEQUATE PERSONNEL WITH THE BEST POSSIBLE TRAINING AND QUALIFICATIONS FOR SUCH SERVICES."

(a) To encourage suitable candidates to enter the study of medicine more scholarships and/or low interest loans should be made available.

(b) Encouragement should be given all doctors to continue to increase their knowledge and efficiency by allowing them to deduct, for income tax purposes, the

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To encourage suitable candidates to enter the study
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(b) Encouragement should be given all doctors to continue
to increase their knowledge and efficiency by allow-



1 cost of attending refresher courses. Also, it
2 would be most advantageous if a planned arrangement
3 could be worked out to provide locum tenens to look
4 after the area, if this is necessary, while a doctor
5 is absent on post-graduate study.

6 (c) The post-graduate program operated by Dalhousie
7 University, with the full cooperation and financial
8 assistance contributed by all members of the New
9 Brunswick Medical Society, should be continued, and,
10 similarly, the refresher courses operated by many
11 other bodies. Through such courses, the continuing
12 developments in the whole field of medical knowledge
13 are presented to the practising physician.

14 (d) In Para. 20 it was mentioned that there is no
15 medical school in this province. We understand
16 that studies on medical manpower requirements for
17 the future are being made by the Canadian Medical
18 Association, and also by the Association of Canadian
19 Medical Colleges, and we felt that the feasibility
20 of establishing a medical school in New Brunswick
21 should be given careful study.

22 (e) Placement Service: This Society has for many years
23 with the assistance of the Medical Council and
24 others, on request, given advice to doctors who are
25 seeking a suitable location in which to take up
26 medical practice. Also, requests received from
27 communities for doctors to settle there are dealt
28 with, insofar as is possible. It is felt that this
29 service has been of considerable value, and should
30 be continued.



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(e) Placement Service: This Society has for many years with the assistance of the Medical Council and others, on request, given advice to doctors who are seeking a suitable location in which to take up medical practice. Also, requests received from communities for doctors to settle there are dealt with, insofar as is possible. It is felt that this service has been of considerable value, and should



52 (f) "THE PRESENT PHYSICAL FACILITIES AND THE FUTURE
REQUIREMENTS FOR THE PROVISION OF ADEQUATE
HEALTH SERVICES."

The situation on the present facilities
is included in our reply to Term of Reference (a) in
Paras. 36, 38 and 39.

The New Brunswick Medical Society does
not maintain a statistical department and depends upon
the Department of Health and other agencies, such as the
Dominion Bureau of Statistics, for such information.

In actual practice, in this province,
the development of additional hospital accommodation, and
the site in which it is to be placed, is worked out
through full consultation between the planning division
of the Department of Health, the doctors in the area, and
the community concerned.

It is believed that more detailed
forecasts of future requirements will be presented in the
Brief of the Department of Health.

53. (g) "THE ESTIMATED COST OF HEALTH SERVICES NOW BEING
RENDERED TO CANADIANS, WITH PROJECTED COSTS OF
ANY CHANGES THAT MAY BE RECOMMENDED FOR THE
EXTENSION OF EXISTING PROGRAMS OR FOR ANY NEW
PROGRAMS SUGGESTED."

The answer given to Term of Reference
(f), Para. 52 applies equally to Term of Reference (g).

54. (h) "THE METHODS OF FINANCING HEALTH CARE SERVICES
AS PRESENTLY SPONSORED BY MANAGEMENT, LABOUR,
PROFESSIONAL ASSOCIATIONS, INSURANCE COMPANIES
OR IN ANY OTHER MANNER."

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54. (h) "THE METHODS OF FINANCING HEALTH CARE SERVICES

AS PRESENTLY SPONSORED BY MANAGEMENT, LABOR,

OR IN ANY OTHER MANNER."



1 This Term of Reference (h) has been
2 referred to in paragraphs 26 - 42, and we feel that we
3 have nothing of value to add to the remarks already made.

4 55. (1) "THE METHODS OF FINANCING ANY NEW OR EXTENDED
5 PROGRAMS WHICH MAY BE RECOMMENDED."

6 (a) The New Brunswick Medical Society has always favoured
7 the premium method of financing, on the grounds that
8 the individual recipient should pay directly for at
9 least a portion of the services he receives. For a
10 new program of Prepaid Medical Care for the indigent
11 groups it is our feeling that this should be under
12 a premium method and, for those who are unable to
13 pay, that the Government should pay the premium
14 for them - for those persons who can pay part of
15 the cost themselves, assistance from Government
16 should be provided. It is our view that Blue Shield,
17 which derives its income from a premium, has proven
18 the efficacy of the method.

19 (b) In regard to paying for extended services under the
20 Hospital Care program, in this province the method
21 to be used to provide the money is entirely a
22 Government decision.

23 56. (j) "THE RELATIONSHIP OF EXISTING AND ANY RECOMMENDED
24 HEALTH CARE PROGRAMS WITH MEDICAL RESEARCH AND
25 THE MEANS OF ENCOURAGING A HIGH RATE OF
26 SCIENTIFIC DEVELOPMENT IN THE FIELD OF MEDICINE
27 IN CANADA."

28 At the present time in this province
29 there is a limited amount of organized research being
30 carried out by certain individual doctors for the DVA



1 authorities. It would seem to us that a great deal of
2 useful research could be carried out on the problems of
3 the elderly citizen, with an improved setup for chronic
4 and custodial beds.

5 57. (k) "THE FEASIBILITY AND DESIRABILITY OF PRIORITIES
6 IN THE DEVELOPMENT OF HEALTH CARE SERVICES."

7 It seems to us that first priority
8 should be given to ensuring that existing services are as
9 efficient as it is possible to make them. Therefore, we
10 would give first priority to the provision of sufficient
11 chronic and convalescent beds, and rehabilitation facilities,
12 and the supply of the necessary personnel to man all
13 types of hospital accommodation.

14 We would give priority, also, to the
15 development of all means of increasing the numbers of
16 suitable candidates entering the study of medicine, to
17 the encouragement of qualified doctors to remain in New
18 Brunswick, and to the encouragement of doctors to locate
19 in those areas which are not now sufficiently supplied;
20 and also to the provision of Prepaid Medical Care Insurance
21 to those groups of the population not now covered.

22 58. (1) "SUCH OTHER MATTERS AS THE COMMISSIONERS DEEM
23 APPROPRIATE FOR THE IMPROVEMENT OF HEALTH
24 SERVICES TO ALL CANADIANS."

25 59. We realize that some of the information
26 presented in this Brief is incomplete, and that we do not
27 have actual statistical evidence to serve as a basis for
28 some of the opinions expressed.

29 We believe, however, that the description
30 of the present situation, and the opinions



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APPROPRIATE FOR THE IMPROVEMENT OF HEALTH SERVICES TO ALL CANADIANS.

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We believe, however, that the description of the present situation, and the opinions



1 expressed, reflect accurately the knowledge and opinions
2 of the doctors who provide the services to the public.

3 As we are among the first of the
4 provinces to make a submission to the Royal Commission,
5 and as the work of the Royal Commission is in its early
6 stages, we desire to assure the Royal Commission on Health
7 Services that we would be pleased to undertake any further
8 studies which they feel are indicated, and also, we
9 would appreciate it if an opportunity might be given for
10 us to present further information if circumstances so
11 indicate.

12 DR. WHITEHEAD: The first part of
13 the brief deals with the existing situation with regard
14 to registration and licensing under the Medical Council.
15 Item 1 says:

16 1. The present system of Registering and
17 Licensing doctors in New Brunswick is satisfactory,
18 but can be subjected to Amendments, as in the past,
19 calculated to enforce additional standards as
20 required.

21 Item 2, I am afraid, sir, that we
22 will ask you to correct these figures. We have had three
23 different census figures during the preparation of this
24 brief. The figure was 606,000 population; later somebody
25 told us it was 611,000, and in the newspapers a few days
26 ago we were told it was 585,000.

27 2. The overall ratio of doctors to
28 population has improved from 1 : 1530 in 1950, to the
29 present ratio of 1 : 1257, with the ratio of
30 Specialists relatively high at 40% of the total. The

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1 present ratio of 1 : 1257, however, is below the present
2 National average of 1 : 888. Practically all doctors
3 in the province are engaged in providing their services
4 directly to the public.

5 And I would comment there that there
6 is no medical centre in this province, there are no
7 research centres, and these factors would need to be taken
8 into account in assessing the ratios, satisfactory or
9 otherwise.

10 3. The shortage of doctors exists partic-
11 ularly in certain areas.

12 4. The distribution of Specialist Care
13 has improved greatly in recent years, - and recent
14 years being in about the last ten or fifteen years,
15 to the point now where the distribution of specialists
16 care is pretty good.

17 5. Most practising doctors continue to
18 practice as individuals, under the existing system
19 of Private Practice. And I believe we do have
20 groups of doctors associated where the members of
21 those groups still function as individuals, much
22 the same as if they were actually in solo practice.

23 6. The vast majority of doctors' services
24 are provided under Private Practice, the main excep-
25 tions being those services provided directly by
26 Government Departments, e.g. In-Hospital Care for
27 Tuberculosis and Mental Illness.

28 7. The Maritime Hospital Service
29 Association (Blue Shield) is the Plan of Prepaid
30 Medical Care sponsored by the New Brunswick Medical

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1 Society. One might add, sir, that in 1959 official
2 approval of the Medical Society was given to that
3 body, which was renewed each year at the annual meet-
4 ing until 1960 when the official approval became
5 official sponsorship.

6 8. When the Cooperation with the Department of
7 Health is excellent.

8 With your permission, sir, I would
9 wish to turn to paragraph 31 which appears on page 11.

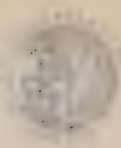
10 Is it permissible, in these proceedings to refer to other
11 briefs?

12 THE CHAIRMAN: Yes, certainly. Not
13 only permissible, it is desirable if to do so is going to
14 be of assistance.

15 DR. WHITEHEAD: We wish to read
16 paragraph 31 on page 11 in full.

17 " Relationship between the Society and
18 the Department of Health has been very close through
19 the years. Consultation between the Department and
20 the Society has always been held on any proposal under
21 which payment for the services of private practitioners
22 is being offered by the Government to the public.
23 Probably the best example is the evolution of the
24 Cancer Program, wherein, at each step, the approval
25 of the Medical Society has been given to the policy
26 and detail before the announcement has been made to
27 the public."

28 We wish, sir, to have incorporated into the record the
29 following: This brief was prepared in September, and
30 finally approved by our executive on October 5th, and



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body. One might add, sir, that in 1959 official approval of the Medical Society was given to that body, which was renewed each year at the annual meeting until 1960 when the official approval became official sponsorship.

8. Cooperation with the Department of Health is excellent.

With your permission, sir, I would wish to turn to paragraph 31 which appears on page 11. Is it permissible, in these proceedings to refer to other briefs?

THE CHAIRMAN: Yes, certainly. Not only permissible, it is desirable if to do so is going to be of assistance.

DR. WHITFIELD: We wish to read paragraph 31 on page 11 in full.

"Relationship between the Society and the Department of Health has been very close through the years. Consultation between the Department and the Society has always been held on any proposal under which payment for the services of private practitioners is being offered by the Government to the public. Probably the best example is the evolution of the Cancer Program, wherein, at each step, the approval of the Medical Society has been given to the policy and detail before the announcement has been made to the public."

We wish, sir, to have incorporated into the record the following: This brief was prepared in September, and finally approved by our executive on October 25th, and



1 mailed to Ottawa on October 14th. We wish to make it
2 clear to the Commission that the Medical Society was not
3 consulted on the content of certain parts of the brief
4 submitted by the Department of Health yesterday, and we
5 refer particularly to section (n) of that brief which
6 deals with the projection of costs of health services
7 presently not provided from public funds. Continuing
8 with the additional statement we wish to make, we do not
9 know whether the priorities and principles expressed in
10 that brief actually represent the considered policy of
11 our government, and we would sincerely hope that the
12 concept of consultation between the department and the
13 Society will continue before policy has been determined.
14 That is the additional item, sir.

15 Back now, sir, to item 9 on page 1
16 of the preface.

17 9. The Professional Training Grants
18 require a thorough study including the regulations
19 governing them as it is believed that a large pro-
20 portion of those trained by New Brunswick ultimately
21 leave the province. That information actually came
22 to us from several sources, and we feel that it is
23 desirable that the set up of these training grants
24 be explored with a view to improving their efficacy
25 for training purposes for specific categories in
26 this province.

27 10. 90% of the total cost of Mental
28 Health Care is paid from Provincial sources. It
29 would have been better said, sir, from Provincial
30 Government funds, municipal funds and a small portion

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would have been better said, sir, from Provincial

Government funds, municipal funds and a small portion



1 from individuals, and the reason for putting it in
2 that way was because it was something we didn't know
3 very well ourselves, that only about 10% of the cost
4 of dental health care in this province is borne from
5 the federal sources. In some other fields of work
6 the proportion is much higher.

7 11. The Diagnostic and Treatment Services
8 provided for Cancer are fully modern. We wish to
9 make that clear, that the expanded cancer programme
10 went into effect on the 1st of April whereby
11 diagnostic and treatment services of proven cases of
12 cancer in hospital are now paid by the Department
13 of Health, that the service is offered to the public
14 are fully modern and up-to-date, both in personnel
15 and equipment.

16 12. The availability of beds of the
17 active treatment type is now fairly adequate, with
18 the exception of two hospital areas in which steps
19 are now being taken to correct the deficiency.
20 Several smaller hospitals should be replaced.

21 There are no convalescent or chronic
22 hospitals as such, and there is a definite need for
23 this type of accommodation.

24 13. The Medical Society is active in the
25 formation and operation of medico-lay organizations.
26 Indeed, sir, I would say that in practically every
27 one of them the Medical Society is represented either
28 on the board or on the committee.

29 14. The members of the Medical Society
30 are willing to make a definite contribution in order



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14. The members of the Medical Society



1 to get a Plan into effect under which Prepaid Medical
2 Care may be made available for indigent persons and
3 needy Elderly citizens. The word elderly would have
4 been better left out, because the intent is need.
5 The total number in the official Welfare Group is
6 46,300 -- which was the accurate number obtained from
7 the Department about two weeks ago -- with an
8 additional undetermined number of medically indigent
9 persons not included in the Welfare Groups. And we
10 would like to say that we have not been able to get
11 what this undetermined number is. It apparently
12 requires considerable research, and various estimates
13 have been given to us, but they are not accurate.

14 15. The supply of para-medical personnel
15 in many categories is deficient. We have not been
16 able to undertake a factual survey on this position,
17 but we know in many categories there are deficiencies.

18 16. The Medical Profession is concerned
19 with the total medical care of the total population
20 on a continuous basis. The methods and extent of
21 paying the doctor for his services vary considerably
22 but the doctor must assume any gap between the
23 offering and full medical attention. What we are
24 trying to say there, sir, is exemplified in the
25 cancer treatment program. At the moment the treatment
26 of cancer in hospital is paid for. The patient is
27 discharged from hospital either cured or their
28 condition alleviated or discharged awaiting the
29 termination of his condition, then that service is
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not provided.



17. The quality of Medical Care is high and all factors which have contributed to the maintenance and improvement of quality should be continued. We assume there that all things, hospitals, etcetera, are more desirable and should be continued.

18. There are many methods of providing doctors' services, but a change of method would not, of itself, produce better medical care.

19. In the existing system of Private Practice several important factors exist:

(a) The doctor is working for his patient directly.

(b) The present manpower is utilized to full advantage

under existing conditions of initiative and

competition.

(c) The patient is free to choose and change his medical attendant; the doctor is free to choose the type and location of his practice.

20. The deficiencies in the existing facilities and methods are tabulated. (Page 25)

Paragraph 47 beginning on page 25, with your permission, sir, I would like to read those in full. This brings us to the end of our studies under item (a) of the terms of reference.

47. "We shall now endeavour to set down the deficiencies which we believe to exist, in the existing facilities and methods:

(a) Inadequate chronic and convalescent beds and rehabilitation facilities, reducing the effectiveness of the acute bed accommodation, producing lengthy waiting lists and postponement of necessary treatment.

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terms of reference.

21. "We shall now endeavour to set down

the deficiencies which we believe to exist, in the

(a) inadequate chronic and convalescent beds and

rehabilitation facilities, reducing the effectiveness

of the acute bed accommodation, producing lengthy

waiting lists and postponement of necessary treatment.



- 1 (b) Diagnostic services to out-patients should be included
2 as insured services under the Hospital Care Plan.
- 3 (c) Deficiency in facilities for transfer of sick people
4 from their own area to the point where hospital and
5 medical services for their particular condition can
6 best be provided - road and air ambulance services
7 should be improved.
- 8 (d) There is a need for a definite program of Prepaid
9 Medical Care Insurance for the medically indigent,
10 and currently uninsurable groups of the population,
11 and also for the provision of essential drugs.
- 12 (e) Considerable study should be given to the social
13 and general welfare of our elderly citizens, in
14 addition to and distinct from the strictly medical
15 care of these persons.
- 16 (f) There is a need for a greater degree of supervision
17 by Government or other regulatory body over the
18 Medical Care Insurance being sold to the public.
- 19 (g) There is a deficiency in the care of the mentally
20 ill, and a need for accommodation and care for
21 children who are mentally deficient or otherwise
22 seriously handicapped.
- 23 (h) There is a grave problem in this province in obtain-
24 ing and holding adequate trained staff to carry out
25 the programs in all divisions of the Department of
26 Health.
- 27 (i) There is a need for more General Practitioners in
28 various parts of the province, and for certain
29 Specialists in certain areas.
- 30 (j) There is a need for a better supply of para-medical



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(i) There is a need for more General Practitioners in
various parts of the province, and for certain
specialists in certain areas.
There is a need for a better supply of para-medical



1 personnel in practically all categories.

2 (k) There is a need for a concerted attack on the
3 problem of the prevention of traffic accidents.

4 21. Comments on the correlation of exist-
5 ing facilities with recommendations to correct
6 deficiencies are specified. (pp 27)

7 22. Comments on means of increasing the
8 supply of general practitioners are given. (Page 27).

9 And I would like to read those in full, sir. This
10 refers to term of reference (c).



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refers to term of reference (c).



(c) "THE CORRELATION OF ANY NEW OR IMPROVED PROGRAM
WITH EXISTING SERVICES WITH A VIEW TO PROVIDING
IMPROVED HEALTH SERVICES."

(a) The deficiencies noted in regard to provision of
convalescent beds, ambulance services, etc. should,
in our view, be corrected by extensions to the
existing Hospital Care program.

(b) The deficiency regarding Prepaid Insurance for
indigent groups should be corrected by correlating
a new offering by the existing Blue Shield organiza-
tion, with the policy-making body made up of repre-
sentatives of the Provincial Government, Municipali-
ties, Medical Society and Blue Shield.

(c) The deficiency regarding Insurance Contracts should
be corrected by correlation with the existing
supervision of insurance by the Provincial Government
or other regulatory body. Minimum standards and
regulations for all contracts should be clearly
defined.

(d) In our opinion, the deficiency in the care of the
mentally ill requires comprehensive study with regard
to,

1. Necessity of expansion of hospital facilities to

(a) Mental Hospitals.

(b) Psychiatric Units in General Hospitals

(c) Institutions for the mentally deficient

2. The role of Community Health Care

(a) Family practice

(b) Specialist practice

(c) Mental Health Clinics



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(c) Mental Health Clinics



(d) Local Mental Health Societies

3. Training and maintaining adequate trained personnel

(a) Psychiatrists

(b) Psychologists

(c) Psychiatric Social Workers.

4. Promotion of research into basic causes of Mental Illness.

(e) Comments on personnel are contained in Paragraph 50.

(d) "THE PRESENT AND FUTURE REQUIREMENTS OF PERSONNEL TO PROVIDE HEALTH SERVICES."

(a) It is difficult to specify how many more doctors are actually required in this province, but it would seem that the overall ratio should be considerably improved over what it is now (1 : 1257). The number of doctors has increased each year for the past several years, and there are now more New Brunswick men pursuing the study of Medicine than there have been at any time for many years. Even with these factors in mind, steps should be taken to increase the numbers of suitable candidates entering the medical schools. It is felt that more scholarships and/or low interest loans should be made available.

At this point, Mr. Chairman, I would introduce an item of information which was not available to us at the time this brief was written. There is a new educational loan programme under our government, under the Department of Youth and Welfare, and this sheet was given to me yesterday and shows as follows, that there are twelve medical students at the moment receiving



(a) Psychiatrists

(b) Psychologists

(c) Psychiatric Nurses

4. Promotion of research into basic causes of Mental

(e) Comments on personnel are contained in Paragraph 50.

(d) "THE PRESENT AND FUTURE REQUIREMENTS OF PERSONNEL

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to us at the time this brief was written. There is a new

the Department of Youth and Welfare, and this sheet was

given to me yesterday and shows as follows, that there

has been a steady increase in the number of students



1 assistance from this fund, and they are distributed as
2 follows: one at the University of Montreal; five at
3 Laval; three at Dalhousie; one at Queen's; two at Ottawa;
4 one pre-medical student at Mount Allison University.

5 I am not absolutely up-to-date on
6 this, but I understand these are loans to a maximum
7 amount of \$500.00 per year, for I believe the term of the
8 university training, that they are interest-free and
9 repayable under the same conditions that they were granted,
10 that would be \$500.00 a year.

11 As a matter of interest, there are
12 two gentlemen in dentistry, four in pharmacy, four in
13 nursing, and two in optometry.

14 23. There is a pressing problem in the supply and
15 retention of Specialist services in all Divisions
16 of the Department of Health.

17 24. Although some of the information presented is
18 incomplete, we believe that the description of
19 the present situation, and the opinions expressed,
20 reflect accurately the knowledge and opinions
21 of the doctors who provide the services to the
22 public.

23 I would now, sir, read the recommen-
24 dations without comment at this time.

25 1. THAT the inadequacy of chronic and convalescent beds
26 and Rehabilitation facilities, the provision of
27 smaller hospitals in certain areas, the deficiency
28 in ambulance services, the deficiency in supply of
29 personnel to man all types of hospital accommodation,
30 and the provision of diagnostic services to out-

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1 patients as insured services, be corrected by
2 extension of the Hospital Care Plan.

3 THAT the recommendations being submitted by the
4 Department of Health re requirements for beds, etc.
5 be considered as minimal requirements.

6 THAT the Professional Training Grant be reviewed
7 including the regulations governing it.

8 2. THAT all steps be taken to increase the number of
9 suitable candidates entering the study of medicine,
10 to encourage qualified doctors to remain in New
11 Brunswick, and to locate in areas not now sufficiently
12 supplied.

13 3. THAT a new Prepaid Insurance Plan for medically
14 indigent persons, and other persons currently un-
15 insurable, be developed through the cooperation of
16 the Provincial Government, Municipalities, Medical
17 Society, and Blue Shield, and that it be operated
18 by the Blue Shield using the premium method to
19 finance it.

20 THAT essential drugs for these groups be provided.

21 4. THAT Prepaid Medical Care Insurance for those groups
22 who are not now covered, and who are not medically
23 indigent, be made more available to individuals
24 through correlated efforts of all parties concerned.

25 5. THAT a greater degree of supervision by the Provincial
26 Government or other Regulatory Body be applied to
27 the sale of Medical Care Insurance in this province.

28 6. THAT the whole program for the mentally ill be given
29 comprehensive study.

30 7. THAT the present standards and requirements for

patients as insured services, be corrected by

extension of the Hospital Care Plan.

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Department of Health re requirements for beds, etc.,

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including the regulations governing it.

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3. THAT a new Prepaid Insurance Plan for medically

indigent persons, and other persons currently un-

insured, be developed through the cooperation of

the Provincial Government, Municipalities, Hospital

Society, and Blue Shield, and that it be operated

by the Blue Shield using the premium method of

financing it.

THAT a special study for these groups be provided.

4. THAT Prepaid Medical Care Insurance for those groups

who are not now covered, and who are not medically

indigent, be made more available to individuals

through coordinated efforts of all parties concerned.

5. THAT a greater degree of supervision by the Provincial

Government or other Regulatory Body be applied to

the sale of Medical Care Insurance in this province.

6. THAT the whole program for the mentally ill be given

comprehensive study.

THAT the present standards and requirements for



- 1 medical education and registration and standards of
2 practice be continued under present regulatory bodies.
- 3 8. THAT remuneration and terms of service for doctors
4 in employ of Government be placed on a much more
5 competitive basis with other provinces and countries.
- 6 9. THAT more planned research be undertaken.
- 7 10. THAT study be given to the Social and General Welfare
8 of our elderly citizens.
- 9 11. THAT study re the feasibility of establishing a
10 medical school in New Brunswick be undertaken.
- 11 12. THAT the problem of the prevention of traffic
12 accidents be given concerted action.

13 We will be very happy to answer any
14 question.

15 THE CHAIRMAN: Thank you very much,
16 Dr. Whitehead. In the submission you refer to areas
17 where there is a shortage presently existing. Would you
18 care to amplify that geographically, insofar as the
19 province is concerned?

20 DR. NUGENT: To describe the geo-
21 graphical areas?

22 THE CHAIRMAN: In which you say that
23 there is a shortage. You say in your first comment on
24 page 1: "A shortage of doctors exists particularly in
25 certain areas".

26 DR. NUGENT: Well, the areas that
27 are referred to, sir, are areas of Queen's County and
28 areas along the north shore of the province. They are
29 mostly farming and lumbering areas. They are more or
30 less sparsely settled. They include areas which in the

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are referred to, sir, are areas of Queen's County and

areas along the north shore of the province. They are

mostly farming and lumbering areas. They are more or

less sparsely settled. They include areas which in the



1 past did support a resident physician, but which now,
2 because of the shift in population and transport seem
3 no longer able to support them, and yet do at times
4 require physicians in emergency. That is the best answer
5 I can give you.

6 THE CHAIRMAN: Thank you very much.

7 MR. HALL: On page 10, paragraph 30,
8 could you tell us what the difference in meaning is
9 between official approval and sponsorship, as you use
10 it in that paragraph?

11 DR. MacDOUGALL: Mr. Chairman, the
12 usual thing with the Medical Society and the Plan up
13 until when first approached in 1950, was the Plan would
14 present to the Association their ideas on prepaid
15 medicine, and indeed, we presented it for two or three
16 years before there was any approval, and at that time
17 the Society because we embodied the principles which were
18 laid down by the local society and the Canadian Medical
19 Association, gave approval to the programme. This meant,
20 of course, that they may approve any programme which met
21 with their requirements. Later on, in 1960, the Society
22 decided to sponsor the Association, which meant that
23 they then took responsibility for certain of the programmes
24 offered, and that they would have a stronger voice in
25 the policy laid down by the Association with regard to
26 prepaid medical services, and to this extent it is on an
27 annual basis sponsoring the Society. They are not the
28 only sponsors. The New Brunswick Medical Society also
29 sponsor the plan, and we are approved by one other
30 medical society.

able to support them, and yet do at times

require physicians in emergency. That is the best answer

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THE CHAIRMAN: Thank you very much.

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only sponsors. The New Brunswick Medical Society also

sponsor the plan, and we are approved by one other



1 MR. HALL: In view of the present
2 status of sponsorship, would the Society be prepared to
3 give official approval to any other association?

4 DR. WHITEHEAD: Yes, sir. This is
5 carefully done, so that the inference is not to the
6 exclusion of something else which might meet the require-
7 ments which we feel are desirable.

8 MR. HALL: On page 2 of the summary,
9 paragraph 14, you state that the Medical Society is
10 willing to make a definite contribution. Could you give
11 us more detail, and explain what you mean by a definite
12 contribution?

13 DR. McINERNEY: That is in general
14 terms. At our last meeting of the New Brunswick Medical
15 Society, as a matter of policy it was declared that we
16 were willing to sit down with bodies who were interested
17 in providing better care for our needy population, and
18 to make a contribution towards the provision of that care.

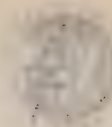
19 MR. HALL: What sort of a contribution?

20 DR. McINERNEY: Well, we would take
21 a, shall we say, a reduction in remuneration, to provide
22 the care for that particular group.

23 MR. HALL: Did you arrive at any
24 decision as to just how far you would go in giving a
25 reduction?

26 DR. McINERNEY: No, no decision as
27 to the extent of the reduction.

28 MR. HALL: Did you define or limit
29 the group to which you were prepared to give such a
30 reduction?



MR. HALL: In view of the present

circumstances, would the Society be prepared to

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1 DR. McINERNEY: It would be at the
2 institution of a means test to decide who was in need
3 for the provision of medical care through a reduced
4 premium or reduced provision of medical services at a
5 reduced cost.

6 MR. HALL: A means test set and
7 conducted by whom, your association, or someone else?

8 DR. McINERNEY: No, I think it would
9 probably be able to dove-tail in with our present
10 administration set-up in welfare, which has been inaugurated
11 in the province within the last eighteen months, and
12 coupled with that you have another safe-guard, in that
13 the medical profession themselves would be directly con-
14 cerned, and on the spot, able to appraise the situation
15 and approve or disapprove, and raise a complaint if there
16 were abuses.

17 DR. WHITEHEAD: Mr. Chairman, there
18 is a gap in this of course. This resolution of the
19 Medical Society was passed only on September 2nd, and
20 there has not yet been suitable opportunity for discussions
21 to take place with the Departments of Government and
22 welfare authorities in municipalities and so on, so at
23 this point we are indicating a policy and it has not been
24 proceeded with, the implementation thereof.

25 MR. HALL: Do you intend to pursue
26 that phase of it?

27 DR. WHITEHEAD: Yes, sir.

28 MR. HALL: On page 26, sub-paragraph
29 d, and again on page IV of the summary you make reference
30 to people who are currently uninsurable. What do you

to people who are currently uninsurable. What do you

MR. HALL: On page 26, sub-paragraph

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1 mean by currently uninsurable?

2 DR. MacDOUGALL: Well, the first
3 group would be perhaps the documented proof of medically
4 indigent listed with the Department of Welfare, and which
5 Dr. Whitehead made reference to a specific number
6 presently documented or in receipt of some aid from the
7 provincial government. I think that was 46 or 47
8 thousand. Another group would be those over the age in
9 which they presently can get in for insurance coverage
10 from the present carriers operating in the province.
11 There are those who have chronic illnesses which do not
12 permit them to come in on the individual contract who
13 may be within the ages of up to, we will say, sixty-five
14 years of age. Generally speaking, these would be
15 classified as your uninsurables. The older, the indigent,
16 and those with medical conditions excluded in individual
17 contracts.

18 DR. MELANSON: May I add to Dr.
19 MacDougall's statment that at the present time through
20 common practice we do not feel that these groups so
21 designated are in want regarding medical health. We have
22 been looking after them by tradition and by volition
23 for years, and the suggestions put forth originally by
24 the Medical Society would be to extend them a form of
25 prepayment whereby they would earlier seek medical
26 attention, and they would have pride and security in
27 going to a physician, whether actually needy, and indigents
28 now frequently, through pride possibly, do not consult
29 a physician early enough.



1 MR. HALL: Would you give consider-
2 ation to the source of payment of the premiums of these
3 people?

4 DR. WHITEHEAD: We specify that here
5 some place in our recommendations. We refer to that, and
6 I will read it because I think it is about the best
7 answer I can give. Page 4 of the summary, item 3:

8 "That a new prepaid insurance plan for medically
9 indigent persons, and other persons currently
10 uninsurable, be developed through the cooperation
11 of the provincial government, municipalities,
12 Medical Society, and Blue Shield, and that it be
13 operated by the Blue Shield using the premium
14 method to finance it."

15 Your question was in regard to where the money would come
16 from?

17 MR. HALL: Yes.

18 DR. WHITEHEAD: Well, it would have
19 to come from the government sources --- provincial or
20 municipal or both.

21 MR. HALL: Raised through taxation,
22 I assume you mean?

23 DR. WHITEHEAD: Yes.

24 MR. HALL: Do you think there are
25 any members of the community who should not be classed as
26 medically indigent persons or not classed as persons
27 currently uninsurable, who may not be able to pay the full
28 amount of the prepaid premium?

29 DR. WHITEHEAD: Yes, sir. I think
30 that is exactly what we are after when we say the official

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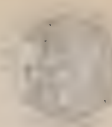
1 welfare groups -- 46,390, or whatever it added up to --
2 those are the people who are now documented and listed
3 with the provincial government and receive allowances of
4 one form or another: for example, Mother's Allowances.
5 Then we know there is a considerable group of people, and
6 we were not able to find out how many; and there are many
7 reasons for that -- how many are what you might call
8 marginally indigent.

9 Another factor is that they may not
10 be medically indigent all the time. A person may be
11 medically indigent only because he is sick at the moment,
12 for a month or two. He might be medically indigent
13 because his wife is sick, and so on; and that group is
14 the one where we feel that those people would have to be
15 identified, and probably they would have to be encouraged
16 to apply to some board to assess their need, and we think
17 also that in many, many cases the doctor will be in the
18 best position to say to these people, "I think you had
19 better apply. You are in a really tough situation and I
20 think you will qualify for some assistance under this
21 programme." -- even if it were only for a temporary
22 period of several months.

23 Does that answer your question?

24 MR. HALL: Not exactly. I had in
25 mind the situation of the cost over the years where they
26 don't make enough income for the cost of the premium, yet
27 they have enough so they would not be classed as indigent
28 under our present standards. What about these people?
29 Have you considered them?

30 DR. WHITEHEAD: Yes.



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28 Have you considered them?



1 MR. HALL: What is your specific
2 suggestion with regard to those people?

3 DR. WHITEHEAD: If they need help
4 we feel they should get it.

5 MR. HALL: How?

6 DR. WHITEHEAD: Through the same
7 method, by having their premium, all of it or an agreed
8 portion of it, paid so that they would have this service
9 available. Have I answered it yet?

10 MR. HALL: I will go to page 16,
11 paragraph 36, sub-paragraph (e), Alcohol and Drug addiction:
12 You say, "No special facilities provided." Have you any
13 recommendation to make as to whether or not facilities
14 should be provided, and if so, what?

15 DR. MacKINNON: Mr. Chairman, if I
16 may: The facilities for the treatment of alcohol and
17 drug addiction at present are limited to the provincial
18 mental hospital, and there are facilities for treating
19 drug addiction in those hospitals. There are regulations
20 about their admission: they can be admitted as voluntary
21 patients, or they can be admitted on the order of two
22 doctors, to be treated. Treatment for alcohol and drug
23 addiction outside of mental hospitals is in the field of
24 private practice, and there are some difficulties here in
25 that these patients are sometimes irresponsible and un-
26 willing or unable to follow medical advice. There is no
27 widespread provincial programme, either in the Medical
28 Society or in the municipalities, for local care of such
29 people. In some places there are mental health clinics
30 to which they can go or be sent for advice and encourage-

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willing or unable to follow medical advice. There is no

to which they can go or be sent for advice and encourage-



1 ment, and in most communities there are chapters of
2 Alcoholics Anonymous which help to deal with the local
3 problem. Does that answer your question?

4 MR. HALL: Part of my question was
5 whether your Association has any specific recommendation
6 to make in regard to this field?

7 DR. MacKINNON: No, we haven't --
8 not specific. It might be included in our general
9 recommendations about the whole field of mental health
10 being studied.

11 COMMISSIONER VAN WART: There is one
12 question I think I would like to ask, and that is in
13 recommendation No. 2 on page 3:

14 "That all steps be taken to increase the number
15 of suitable candidates entering the study of
16 medicine, to encourage qualified doctors to
17 remain in New Brunswick, and to locate in areas
18 not now sufficiently supplied."

19 Would you explain to us what your Society has in mind to
20 implement those suggestions?

21 DR. WHITEHEAD: Yes, sir. I think
22 it is covered about as well as we can on page 28, and
23 there are two facets to this, actually. There is the
24 factor of encouraging suitable men and women to go into
25 the study of medicine, which is long, arduous and expensive,
26 and we recommend somewhere in the brief that there be
27 more student loans, scholarships and bursaries, and that
28 sort of thing, to assist.

29 The location in areas not now suffi-
30 ciently supplied is a problem of its own, and we feel that



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1 the proposal about prepaid medical care for the needy
2 groups of the population would do quite a bit towards
3 assisting and attracting younger men to stay in those
4 areas, even if they only stayed for a period of, say,
5 two or three years. That would give a very good stand-
6 ard of medical care to these areas which they do not
7 have, some of them, now.

8 The other feature which we feel is
9 most important is that in the planning of new beds, and
10 where they are to be, that smaller hospital units --
11 fifteen and twenty bed units -- be strategically placed
12 with this factor in mind as well, the factor of need of
13 a doctor in the area, and particularly if in the planning
14 of these facilities it could include a place which the
15 doctor can use as his headquarters -- his office, and so
16 on; also the provision of adequate para-medical help --
17 not for the doctor actually but for the persons.

18 Does that answer your question?

19 COMMISSIONER VAN WART: Yes.

20 COMMISSIONER STRACHAN: Mr. Chairman,

21 I wonder if we could have more detail regarding the loans
22 which have been mentioned -- the loans to medical and
23 dental students?

24 THE CHAIRMAN: Would Dr. Kelly be
25 about to help us there?

26 DR. C. W. KELLY: Mr. Chairman,
27 these loans have been instituted very recently under our
28 new Department of Youth and Welfare in the provincial
29 government. These loans are a maximum of \$500.00 for
30 each university or school year, and these, I believe, are

the proposal about prepaid medical care for the needy groups of the population would be quite a bit towards assisting and attracting younger men to stay in those areas, even if they only stayed for a period of, say, two or three years. That would give a very good standard of medical care to these areas which they do not have, some of them, now.

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these loans have been instituted very recently under our new Department of Youth and Welfare in the provincial government. These loans are a maximum of \$500.00 for



1 renewable for a period of five years at least -- \$500.00
2 each year. They are entirely interest free. They are
3 repaid on the basis of \$500.00 annually starting six
4 months after the student or trainee has completed his
5 course and qualified for the work which he plans to do.
6 I have not available the return of service, or, in other
7 words, what the student is asked to do in the way of a
8 period of work in the Province of New Brunswick, but I
9 think it is safe to assume that this return of service
10 would last for the number of years which the student is
11 repaying the loan. In other words, if the student had
12 a loan of five years duration at \$500.00 each year, the
13 student would be expected to remain in the Province of
14 New Brunswick and practice his or her profession or
15 trade until this loan was completely repaid, which would
16 mean a total of five years if the loan had been given
17 over this period of time.

18 THE CHAIRMAN: Dr. Kelly, you say
19 that he has to start to repay this within six months
20 after he has finished?

21 DR. C. W. KELLY: Yes.

22 THE CHAIRMAN: Does that contemplate
23 six months after he has finished any post-graduate study?

24 DR. C. W. KELLY: That is six months
25 after he has completely qualified himself or herself and
26 is ready to assume a position in the profession.

27 THE CHAIRMAN: So it could not be
28 a break on post-graduate study in that respect?

29 DR. C. W. KELLY: No, not at all.

30 COMMISSIONER STRACHAN: Could it be

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COMMISSIONER STRACHAN: Could it be



1 used for post-graduate study?

2 DR. C. W. KELLY: No, it cannot be
3 used for post-graduate study in the health field, because
4 the Department of Health is presently covering this.
5 There is one thing about the Department of Health post-
6 graduate training assistance, and it is this: That
7 federal regulations prohibit us from using this for
8 post-graduate study of an individual who plans to engage
9 in the practice of his trade or profession under private
10 enterprise. If, for example, a physician in this province
11 asked for post-graduate study other than short courses
12 -- we can do it for short courses under the National
13 Health Grants -- but if he asked for a prolonged course
14 and he desires to become a paediatrician, and plans to
15 enter private practice after he has completed his post-
16 graduate study, our National Health Grants regulations
17 prohibit us from assisting him in this field. If he is
18 going to become a paediatrician, and provide his service
19 as an employee, for example, or if he is going to become
20 a paediatrician and provide his services under the
21 sponsorship of the Department of Health, then we can.
22 If he is going to become a paediatrician -- and I use
23 this, but all the others apply -- and enter private
24 practice wholly after he completes his course, the
25 National Health Grants prohibit us from doing this.
26 Post-graduate study, we have been able to do for all the
27 people who are employed or providing all their service
28 under the plan or under the sponsorship of the Department,
29 and for short courses we have done this for practising
30 physicians in certain specialties.



1 THE CHAIRMAN: Thank you, Dr. Kelly.

2 Inconnection with this matter of medical education, I
3 see that one of the recommendations you make is the
4 study of the feasibility of establishing a medical school
5 in New Brunswick be undertaken. How soon do you visualize
6 that such an undertaking might be required?

7 DR. WHITEHEAD: Mr. Chairman, what
8 we mean there is that we know, or at least we have been
9 informed that the Canadian Medical Association has already
10 completed a study of the Canadian manpower projected to
11 1980, and we understand the Association of Canadian
12 Medical Colleges is undertaking a study of the pharmacy
13 and medical schools throughout Canada, and we are
14 recommending, as I understand it, that these groups in-
15 clude the possibility of studying the feasibility of
16 establishing one in this province at some time in the
17 future.

18 THE CHAIRMAN: Well, why? Is it
19 something more than provincial pride? Because you will
20 appreciate a medical school is a very expensive under-
21 taking initially in capital costs, currently in operating
22 expense -- it is about as expensive an undertaking as a
23 province can enter upon, isn't it?

24 DR. CLARK: We realize that, Mr.
25 Chairman. This has been discussed for several years, but
26 with the study of this brief the Medical Council considered
27 this point and it was felt from many angles that the
28 feasibility -- and again thinking of provincial pride,
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1 it would give stimulus to the profession in the pro-
2 vince; it would provide more adequate and more readily
3 assessable short courses for physicians without going
4 great distances, and thirdly, and I think a very, very
5 important problem, is the matter of internes. We in
6 New Brunswick, and I think as in other provinces, find
7 the shortage of internes is becoming more acute each
8 year and dependent more and more on foreign graduates
9 from other countries -- India, Greece, Turkey, and so on
10 -- and this group of foreign internes in many cases are
11 very good, but at times it is hard to assess them as
12 well as we can our own Canadian boys, and with a medical
13 school students who would be graduated from the school
14 could be used as internes throughout our province and
15 supply services to many hospitals which today should have
16 interne services but, because of lack of internes, are
17 not getting them, or if they are, are getting wholly
18 inadequate interne service.

19 I think these are the importance
20 factors that we considered. We realized the cost is
21 tremendous and the endowment would have to be great in
22 order to adequately provide such a thing but we feel
23 that the facilities in New Brunswick with hospitals of
24 all types -- D.V.A., Tuberculosis, Mental, and so on --
25 would be adequate to train these men and at the same time
26 would give a stimulus to all these facilities and raise
27 our standards. I think that is about all I can say.

28 THE CHAIRMAN: How many students
29 have you now, do you know, studying medicine from the
30 Province of New Brunswick in the various schools?

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2 provide short courses for physicians without going

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4 New Brunswick, and I think as in other provinces, find

5 the shortage of internists is becoming more acute each

6 year and dependent more and more on foreign graduates

7 from other countries -- India, Greece, Turkey, and so on

8 -- and this group of foreign internists in many cases are

9 very good, but at times it is hard to assess them as

10 well as we can our own Canadian boys, and with a medical

11 school students who would be graduated from the school

12 could be used as internists throughout our province and

13 supply services to many hospitals which today would have

14 internist services but, because of lack of internists, are

15 not getting them, or if they are, are getting inferior

16 inadequate internist services.

17 I think these are the important

18 factors that we considered. We realized the cost is

19 tremendous and the endowment would have to be great in

20 order to adequately provide such a thing but we feel

21 that the facilities in New Brunswick with hospitals of

22 all types -- D.V.A., Tuberculosis, Mental, and so on --

23 would be adequate to train these men and at the same time

24 would give a stimulus to all these facilities and raise

25 our standards. I think that is about all I can say.

26 THE CHAIRMAN: How many students

27 have you now, do you know, studying medicine from the



1 DR. NUGENT: Fifty-four.

2 THE CHAIRMAN: And that is spread
3 over a four year period?

4 DR. NUGENT: Five year period.

5 THE CHAIRMAN: Have you given con-
6 sideration to the minimum number of students necessary
7 for the proper functioning of a medical school?

8 DR. CLARK: Our own recommendation
9 was that this be completely studied. Unless an adequate
10 and thorough study was made, you could not just pick
11 those figures out of the air, and our recommendation was
12 that a study be made with regard to the feasibility of
13 it.

14 THE CHAIRMAN: But we are very much
15 interested in your provincial position in terms of the
16 situation in the four Atlantic Provinces. Do you seriously
17 recommend this, with some knowledge of the effect it
18 would have, say, on the medical school at Dalhousie which
19 is now providing the service for the four Atlantic
20 provinces?

21
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provinces?



1 DR. CLARK: I think the only answer
2 I can give to that, Mr. Chairman, is this, that we know,
3 and I think it is general knowledge, that our medical
4 schools in Canada today are not graduating enough
5 physicians to provide our Canadian population with
6 Canadian doctors, and I understand also that most of the
7 medical schools cannot enlarge their body because of the
8 limited facilities, and so forth. Therefore, as time
9 progresses and population increases, if our medical
10 graduates in Canada do not increase in number, as time
11 goes on our medical services are going to be carried on
12 by men not trained in this country, and this will be a
13 growing gap year by year, it is becoming a greater gap
14 with more foreign-trained physicians.

15 Now, it is not that the foreign-trained
16 physicians are not good, they are excellent, but the gap
17 is widening, and if we don't train physicians in Canada,
18 then we as Canadians would not feel that they are adequate
19 as trained in our own country.

20 THE CHAIRMAN: Have you any infor-
21 mation on the intake of foreign graduates, say, in the
22 last five years in the Province of New Brunswick?

23 DR. NUGENT: From the period of 1950
24 until 1960 there were thirty-seven graduates from non-
25 Canadian schools registered in this province.

26 THE CHAIRMAN: Do the records you
27 have there indicate how many came in 1960, 1959, 1958
28 and so forth, back to, say, 1955?

29 DR. NUGENT: Yes, sir. In 1955 there
30 were thirty-five; in 1956 there were five; in 1957 there



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were thirty-five; in 1960 there were five; in 1957 there



1 was one; in 1958 there were three; in 1959 there were
2 four; in 1960 there were seven.

3 MR. HALL: Mr. Chairman, for the
4 purpose of this discussion, may I say that my information
5 is that the Canadian Medical Association survey shows
6 that in 1960 Nova Scotia accepted sixty-four graduates
7 of foreign schools, and forty-three from Canadian schools,
8 and Newfoundland accepted eighty-three from foreign
9 schools and twenty-four -----

10 THE CHAIRMAN: These are students?

11 MR. HALL: No, accepted as doctors.
12 Twenty-four from Canadian schools, and in 1960 New
13 Brunswick registered seven from foreign schools and
14 twenty-three from Canadian schools.

15 DR. NUGENT: Sir, those figures are
16 correct, but a comparison of the numbers registered in
17 Nova Scotia with New Brunswick and those registered in
18 Newfoundland compared with New Brunswick -- a comparison
19 cannot be made on an equal basis because the requirements
20 of registration for foreign graduates is different as
21 between New Brunswick and Newfoundland and New Brunswick
22 and Nova Scotia.

23 THE CHAIRMAN: What is the difference?

24 DR. NUGENT: The difference is that
25 we will register no one in New Brunswick -- and I speak
26 of citizens or graduates of other countries than the United
27 States, Great Britain and Eire -- we will not accept
28 people, graduates from any other countries unless they
29 graduate as internes for two years in Canada, and one of
30 those two years must be spent in New Brunswick. The

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two years must be spent in New Brunswick. The



1 result of that is that the registration requirements in
2 these other provinces are lower than they are in ours.

3 COMMISSIONER McCUTCHEON: You say
4 they are lower, Doctor, they are different. You have
5 no connection with the British Medical Council?

6 DR. NUGENT: No.

7 COMMISSIONER McCUTCHEON: The other
8 provinces have?

9 DR. NUGENT: Yes. But I am not
10 speaking of graduates of schools from Great Britain or
11 Eirie; we accept them as we do our own students.

12 THE CHAIRMAN: Bring yourselves up
13 to date, Dr. Nugent -- Ireland.

14 COMMISSIONER BALTZAN: Mr. Chairman,
15 Dr. Whitehead, page 1, item 4, reads:

16 "The distribution of Specialist Care has improved
17 greatly in recent years",

18 and you added in the last ten or fifteen years. Question
19 No. 1: Is there overcrowding or over-concentration in
20 some regions, territorial regions, that is in cities,
21 university centres, large hospital centres, etcetera?

22 DR. WHITEHEAD: No, sir. I think
23 the correct answer to that is there is a tendency certain-
24 ly for specialists to congregate where there are larger
25 hospitals and larger towns, but it is an interesting
26 situation that the specialists are very well distributed
27 throughout the province. We do say that there are
28 certain specialities which are short in certain areas.
29 An example would be that there is only one ophthalmologist
30 on the north shore of the province, and I think it is



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no connection with the British Medical Council?

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COMMISSIONER McGLITCHEN: The other

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throughout the province. We do say that there are
certain specialties which are short in certain areas
on the north shore of the province, and I think it is



1 true that there is a shortage of ophthalmologists in the
2 whole province actually. I haven't any figures, but I
3 do know that there are trained anaesthetists in practi-
4 cally all areas now.

5 One might refer to a question of
6 yesterday which I think one of the commissioners asked:
7 the map showed an apparent lack of distribution. The
8 radiological facilities, for instance, are well distri-
9 buted now. In some areas one can have two or three
10 centres on a visiting basis. Does that answer your
11 question?

12 COMMISSIONER BALTZAN: Yes, thank you.
13 Question No. 2, Dr. Whitehead. You practically antici-
14 pated that. Is there a wide disproportion in the number
15 of specialists? You said that your surgeons are pretty
16 well distributed. There are areas where they say there
17 are more surgeons than operations. What is your experience
18 here? You said that there is a shortage of ophthalmologists.

19 DR. WHITEHEAD: The same remarks
20 would apply to E.N.T. specialists; they are in short
21 supply, sir.

22 COMMISSIONER BALTZAN: Number 3:
23 Where there are shortages of particular specialists, do
24 the doctors in the area make a concerted effort to
25 attract an assist and invite specialists like neurologists
26 and so on to come to a particular area, or do they come
27 because they see there is an opportunity?

28 DR. WHITEHEAD: I think, sir, the
29 best answer would be that the situation is not saturated
30 in any field really. Yes, I think the doctors would tend



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25 because they see there is an opportunity?

26 DR. WHITEHEAD: I think, sir, the

27 best answer would be that the situation is not exaggerated

28 in any field really. Yes, I think the doctors would tend



1 to look out to find a man.

2 COMMISSIONER BALTZAN: On page 1,
3 paragraph 2, my question is this: you are speaking of
4 40 per cent of specialists. Could I have your opinion
5 or could the Commission have your opinion relative to
6 this. Are not a high proportion of specialists a response
7 to the demand on the part of the public perhaps as much
8 as a preferred choice by specialists to enter fields?

9 DR. MacKINNON: I think your impli-
10 cation is correct, that it is the public demand that
11 makes specialists in general go to a particular area,
12 or perhaps an interne leaves the area and returns
13 specialized. Many people these days will automatically
14 go to a specialist rather than a medical practitioner.

15 COMMISSIONER BALTZAN: As a corollary,
16 is it not true that the College of General Practice has
17 helped to upgrade, improve the status and prestige in
18 the public image of the private practitioner, that the
19 College of General Practice have attempted to improve
20 and increase the general practitioner's position?

21 DR. CLARK: Mr. Chairman, may I
22 answer that question this way. I was hoping some other
23 member of the panel would answer this question, truthfully,
24 because being one of the original members of the College
25 of General Practitioners we feel we are doing an
26 excellent job in this field, and mainly because we feel,
27 we have concentrated mainly on educational requirements
28 to remain a member, although that small \$100.00 each two
29 years of post-graduate work in order to remain a member,
30 at least it stimulates our general practitioners to



1 improve their status. We purposely, as a College, have
2 stayed away from economic and political fields because,
3 first of all, I belong to the Canadian Medical Society,
4 and, secondly, I think it would weaken our study. I
5 think as our College has progressed over the last seven
6 years the increase in the studies of the members has
7 been very stimulating. I think it has played an import-
8 ant factor, and will continue to play a most important
9 factor as time goes along.

10 COMMISSIONER BALTZAN: Finally,
11 where the tendency might be to enter into the specialties,
12 every effort is being made to go the other direction to
13 encourage men to stay with you and continue on and
14 perhaps increase the number of men in general practice.

15 DR. MacKINNON: If I may add to
16 that, as a specialist, I am in agreement with what you
17 just said, that we feel that the College of General
18 Practitioners has made a great deal of effort and has
19 attained a considerable degree of success in post-graduate
20 work. We need to foster their post-graduate education,
21 make their position more attractive in areas where they
22 are in short supply. We feel that this is one of the
23 ways in which the public will have better general care.
24 Most people need a family physician on whom they can
25 rely, and we would like to encourage the number and the
26 quality of all general practitioners.

27 COMMISSIONER BALTZAN: Thank you,
28 gentlemen.

29 THE CHAIRMAN: Arising out of this,
30 Doctor, how is the matter of group practice developing

...the ...

secondly, I think it would weaken the ...

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quality of all general practitioners.

COMMISSIONER BARTON: Thank you.

THE CHAIRMAN: Coming out of this ...



1 in New Brunswick?

2 DR. McINERNEY: Group practice I
3 think is basically a private practice with co-operation
4 between groups of doctors in the community. In other
5 words, each doctor is a general practitioner, but they
6 work in co-operation.

7 THE CHAIRMAN: Is the idea develop-
8 ing, is it increasing?

9 DR. McINERNEY: It has in the last
10 five years improved in several areas in the province.
11 Actually here in our own locality we have a large
12 group practice set up which has now reached the propor-
13 tion of twenty general practitioners.

14 THE CHAIRMAN: You have your
15 specialists and general practitioners within the group?

16 DR. McINERNEY: Yes, and in the
17 last few years group practice has been inaugurated but
18 still not to the extent it has been in other parts of
19 Canada.

20 THE CHAIRMAN: Does the dispersal
21 of the population have a bearing on whether group practice
22 can go beyond a certain point or not?

23 DR. McINERNEY: It depends on the
24 location. You can have larger groups and smaller groups.
25 One group of three has started practice in one of our
26 smaller towns. So it is not limited to the cities. The
27 smaller towns can support a small group.

28 THE CHAIRMAN: Do you see it as
29 something of a solution in the providing of medical
30 service in these small areas, that is making life more



1 congenial for the doctors?

2 DR. McINERNEY: Not practice as such.
3 In some of the areas you might group two regions, but
4 one of the problems in rural practice is that the doctor
5 is on duty twenty-four hours a day, three hundred and
6 sixty-five days a year. So that practice might be made
7 available to him on a group pool basis. But there may
8 be a situation where you could take in two areas and
9 provide better service for the rural area.

10 COMMISSIONER FIRESTONE: Mr. Chairman,
11 we are very obligated to the New Brunswick Medical
12 Society and the Medical Council of New Brunswick to have
13 made available to us a top team of nine outstanding
14 doctors in the Province of New Brunswick to answer
15 questions that might be put. I would like to use the
16 occasion, gentlemen, to discuss with you some basic
17 questions of principle of providing medical care services
18 in Canada, and particularly here in the Province of New
19 Brunswick.

20 Dr. Whitehead, I am sure you and your
21 associates are familiar with the Order-in-Council which
22 sets out the terms of reference of the Royal Commission.
23 If I may read one sentence, part of a sentence of that
24 Order-in-Council. The Commission is required

25 "to recommend such measures, consistent with
26 the constitutional division of legislative
27 powers in Canada as the Commissioners believe
28 will ensure that the best possible health care
29 is available to all Canadians...."

30 I would like to draw your attention, Dr. Whitehead, to



1 the word "all" and ask whether your Society agrees that
2 we are talking here of the availability of a medical
3 care service programme on a universal basis?

4 DR. WHITEHEAD: Yes, sir, the
5 availability of it.



DR. WHITEHEAD: Yes, sir, the



1 COMMISSIONER FIRESTONE: I would
2 now like to, just for the record, establish that the New
3 Brunswick Medical Society endorses the statement of
4 principles which the Canadian Medical Association ex-
5 pressed and accepted in June 1960 with respect to medical
6 service insurance. Is this statement of principle
7 endorsed by your Society?

8 DR. WHITEHEAD: Yes.

9 COMMISSIONER FIRESTONE: If it is,
10 may I deal with principle No. 1, and I will read it to
11 you:

12 "The Canadian Medical Association believes that
13 the highest standard of medical services should
14 be available to every resident in Canada."

15 Does your Association believe and accept this statement
16 to mean the provision of a comprehensive medical care
17 service programme for everybody in Canada, and that means
18 in the Province of New Brunswick?

19 DR. MELANSON: Mr. Chairman, the
20 New Brunswick Medical Society has adopted these principles
21 and I think that the statement as written does apply
22 definitely to our thinking in this Province.

23 COMMISSIONER FIRESTONE: Does the
24 highest standard of medical services available to every
25 resident cover a comprehensive programme, sir?

26 DR. MELANSON: Would you define what
27 you mean by comprehensive?

28 COMMISSIONER FIRESTONE: Would you,
29 sir, give us your interpretation of what you would under-
30 stand under the term comprehensive medical care programme?

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COMMISSIONER FIRESTONE: Does the

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DR. MITCHELL: Would you define what

you mean by comprehensive?

sir, give us your interpretation of what you would under-

stand under the term comprehensive medical care programme?



1 DR. MELANSON: Well, I would think
2 that the term comprehensive would mean universal.

3 COMMISSIONER FIRESTONE: Universal
4 meaning covering everybody in the province?

5 DR. MacDOUGALL: Mr. Chairman, may
6 I add to what Dr. Melanson said. I don't believe that
7 the medical profession of the Province of New Brunswick
8 can equate comprehensive and universal. I don't think
9 there is any relationship between the two. Comprehensive
10 has to do with the amount of services. Universal has
11 to do with the availability to the public.

12 COMMISSIONER FIRESTONE: That is a
13 very helpful explanation, and this is exactly what I was
14 going to ask next. Thank you for helping me out. If
15 this is the case, and we have already had a reply that
16 you are in favour of a scheme covering everybody, or on
17 a universal basis. Now, in terms of coverage, are
18 you in favour of a comprehensive medical care programme
19 for the people of New Brunswick, Dr. Whitehead?

20 DR. WHITEHEAD: Yes, sir. That would
21 be available to the people of Canada. The context in
22 which we have used, and it may be wrong, but we have used
23 the word comprehensive in paragraph 5 there. In our
24 thinking, as Dr. MacDougall has just said, has been
25 comprehensive in benefit, in service to the individual
26 person, and I have had the privilege, sir, of seeing and
27 hearing the Royal Commission twice, and the word compre-
28 hensive to you, and this is not with any facetiousness
29 or rudeness at all, you are using it I think in the
30 sense of what it does mean, and that is including all

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DR. MacDONNELL: Mr. Chairman, may

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COMMISSIONER FIRESTONE:



1 things, doctor's service, medical care, etcetera, to
2 all people, so we have a little difference in terminolo-
3 gy.

4 COMMISSIONER FIRESTONE: If you wish
5 to pursue this further, I shall be happy to do so. Thank
6 you for initiating the question. When you talk of
7 comprehensive, sir, you refer to a comprehensive medical
8 care service, is that correct, sir?

9 DR. WHITEHEAD: Yes.

10 COMMISSIONER FIRESTONE: When we
11 talk of a comprehensive health care system, what in your
12 opinion and that of your Society would be included in
13 such a programme?

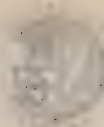
14 DR. WHITEHEAD: In an overall programme.
15 Well, we are the Medical Society, and I suppose we have
16 a one-track mind, because we are primarily concerned with
17 the services of doctors, but in an overall programme,
18 sir, just off-the-bat, I think it should include the
19 provision of essential drugs, dental care, hospitalization
20 and essential nursing services.

21 COMMISSIONER FIRESTONE: Does your
22 Society endorse the desirability for the availability of
23 such a comprehensive health care programme, just as you
24 outlined?

25 DR. WHITEHEAD: That this should be
26 available?

27 COMMISSIONER FIRESTONE: Yes, the
28 desirability for the availability of such a comprehensive
29 health care programme, as defined by yourself?

30 DR. WHITEHEAD: Yes, sir.



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to pursue this further, I shall be happy to do so. Thank

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health care programme, as defined by yourself?

DR. WHITEHEAD: Yes, sir.



1 DR. NUGENT: Under what circumstances
2 would you suggest that, under what arrangement? There
3 is a qualification.

4 COMMISSIONER FIRESTONE: Well, if I
5 may deal with the question in form of questions as we
6 proceed. To come next to the submission which we heard
7 from the representatives of the Department of Health and
8 the Government of New Brunswick yesterday. There is
9 contained in their submission to the Royal Commission,
10 under section N, proposal 3. This, Dr. Whitehead, is
11 the proposal to which you made reference in your opening
12 remarks, having drawn the attention of the Royal
13 Commission that it was drafted and presented without
14 prior consultation with your group, and you expressed
15 the hope that further consultation may take place in
16 this and related matters. I presume that even though
17 your society has not been consulted, you are familiar
18 with section N of that submission, since you commented on
19 it this morning, but just to refresh the memory of the
20 members of your group, proposal No. 3, section N suggests
21 the development of a health care programme which would
22 provide, and I quote:

23 "health services to all the population, excluding
24 those covered by present Acts of federal and
25 provincial jurisdiction",
26 and then that paragraph continues to say:

27 "the plan would include prescribed drugs".
28 Would you support such a plan, sir?

29 DR. MacKINNON: Sir, section N,
30 priority C, is that where you are reading?

DR. MACLENNON: Sir, section 11.

Would you support such a plan, Sir?

"The plan would include prescribed drugs."

and then that paragraph continues to say:

"provisional legislation."

those covered by present Acts of Federal and

"Health services to all the population, excluding

providing, and I prefer

the development of a health care programme which would

members of your group, proposal No. 3, section 11 suggests

in this meaning, but that to reflect the memory of the

with section 11 of that legislation, since you come two on

your society has not been consulted, you are talking

this and related matters. I presume that even though

the hope that further consultation may take place in

prior consultation with your group, and you expressed

Commission that it was drafted and presented without

remarks, having drawn the attention of the Royal

the proposal to which you made reference in your opening

under section 11, proposal 3. This, Mr. Whitehead, is

contained in their submission to the Royal Commission,

the Government of New Brunswick yesterday. There is

from the representatives of the Department of Health and

proceed. To come next to the submission which we heard

may deal with the question in form of questions as we

COMMISSIONER KILPATRICK: Well, Sir,

What, under what circumstances?

DR. NUGENT: Under what circumstances?



1 COMMISSIONER FIRESTONE: Yes, that
2 is right.

3 DR. MacKINNON: We are not in favour
4 of a complete medical care plan for all the population
5 being covered, being provided by any government. With
6 reference to your previous remarks about the availability
7 of a comprehensive plan, the availability of medical
8 services in this province is to a degree in existence
9 now. We have doctors, nurses, drugs are available,
10 hospitals are available, rehabilitation is available.
11 The degree to which it is obtainable by the population
12 depends to a great degree on their financial status,
13 whether they can buy themselves insurance, or whether
14 they have to get these services through municipal assis-
15 tance, or other forms of financial aid. As far as
16 government putting in a plan whereby everybody will be
17 covered, we agree with the terms of the Canadian Medical
18 Association, that a compulsory tax supported plan is not
19 what we want.

20 COMMISSIONER FIRESTONE: Thank you for
21 expressing those views, Doctor. I am planning to come
22 back to No. 5 of the statement of the C.M.A., and we will
23 then discuss the questions which you have raised when we
24 come to this point. If I may just stick for a moment to
25 the proposal which we have heard, or the priority which
26 the Government of the Province of New Brunswick has
27 suggested as a possible programme, do I understand, Dr.
28 Whitehead, that your Society would be in favour of a
29 comprehensive medical care plan, but you would not be in
30 favour of such a plan if it were instituted by a government

DR. MACKINNON: We are not in favour

of a complete medical care plan for all the population being covered, being provided by any government. With reference to your previous remarks about the availability of a comprehensive plan, the availability of medical services in this province is to a degree in existence now. We have doctors, nurses, drugs are available, hospitals are available, rehabilitation is available. The degree to which it is obtainable by the population depends to a great degree on their financial status.

they have to get these services through municipal assistance, or other forms of financial aid. As far as government having in a plan whereby everybody will be covered, we agree with the terms of the Canadian Medical Association, that a compulsory tax supported plan is not what we want.

COMMISSIONER WINTHROP: Thank you for

expressing these views, Doctor. I am planning to come back to No. 5 of the statement of the C.M.A., and we will then discuss the questions which you have raised when we come to this point. If I may just stick for a moment to the proposal which we have heard, or the priority which the Government of the Province of New Brunswick has suggested as a possible programme, do I understand, Dr. Wintrop, that your Society would be in favour of a comprehensive medical care plan, but you would not be in favour of such a plan if it were instituted by a government?

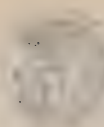


1 or governments, or would you be more concerned in having
2 a plan that is practicable and realistic implemented,
3 whatever the source, whether it is private or public, or
4 a combination of private and public. What are the views
5 of your Society as to the sponsorship of the programme?

6 DR. WHITEHEAD: Well, sir, what we
7 believe in actually is a prepaid medical system available
8 to everyone. We don't actually have any objections, and
9 in fact we have proven that, to tax support, because if
10 we did we would not be living with our present programme
11 in tuberculosis for example, and in our proposals we have
12 made a very definite statement that we would expect tax
13 funds to be used to pay the premiums of those who are
14 in need of their premium being paid. For those segments
15 of the population who are able to pay their own premiums,
16 it is our feeling that it should be available to them,
17 that the services should be as comprehensive as can be
18 made, and that any person who desires to avail himself
19 of this method of budgeting his illness costs, and other
20 costs too, dental and so on, should have the privilege
21 of doing so. I think we reserve the feeling that this
22 would be preferable to a plan instituted, controlled, and
23 run entirely by the government. That we would not be
24 in favour of that.

25 COMMISSIONER FIRESTONE: Would you be
26 in favour of a plan that involves the participation of
27 private institutions and governments?

28 DR. WHITEHEAD: Yes, sir, I think so.
29 I think we would have to be. We have said that actually
30 in regard to this first step, which really what we are



DR. WHITEHEAD: Well, sir, what we

believe in actually is a complete medical system available to everyone. We don't actually have any objections, and in fact we have proven that, to the extent, before we did we would not be living with our present problems in connection with the system, and in our proposals we have made a very definite statement that we would expect the funds to be used to pay the premiums of those who are in need of their premium being paid. For those members of the population who are able to pay for their own insurance, it is our feeling that it should be available to them, that the service should be as comprehensive as can be made, and that any person who desires to avail himself of this method of budgeting his illness costs, and other costs too, dental and so on, should have the privilege of doing so. I think we reserve the feeling that this would be preferable to a plan limited, controlled, and run entirely by the government. That we would not be in favour of that.

COMMISSIONER THURSTON: Would you be

in favour of a plan that involves the participation of private institutions and governments?
DR. WHITEHEAD: Yes, sir, I think so. I think we would have to see. We have said that actually we are and believe that step, which really what we are



1 doing, the stage of development that we are in, is first
2 of all, we don't have a plan on a provincial basis for
3 the people in need, and we have said that we need the
4 tax money to pay for it, and we think it should be run,
5 the policy should be made by representatives of the
6 provincial government, of the municipalities, and of our-
7 selves, and also we could add to that representatives of
8 those who are receiving the services in some proportion
9 or other.

10 COMMISSIONER FIRESTONE: In other
11 words, the representatives of the public?

12 DR. WHITEHEAD: Correct.

13 COMMISSIONER FIRESTONE: So you are
14 in favour of a programme which combines the best of
15 private initiative with government participation?

16 DR. WHITEHEAD: Yes.

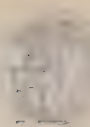
17 COMMISSIONER FIRESTONE: May I now
18 turn to your brief, page II, paragraph 16 of the summary.
19 You say:

20 "The medical profession is concerned with the
21 total medical care of the total population on a
22 continuous basis".

23 Would you be good enough, Dr. Whitehead, to define total
24 medical care?

25 DR. MacKINNON: That means, sir, having,
26 one, a doctor available to any patient for any illness
27 at all times, plus such help as he may need, such as the
28 availability of drugs, hospitals, transportation facilities,
29 rehabilitation, nursing care, etcetera.

30 COMMISSIONER FIRESTONE: Would you



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tax money to pay for it, and we think it should be paid

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provincial government, of the municipalities, and of our-
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those who are receiving the services in some proportion
or other.

COMMISSIONER FIRESTONE: In other

words, the representatives of the public?

DR. WHITEHEAD: Correct.

in favour of a programme which combines the best of
private initiative with government participation?

DR. WHITEHEAD: Yes.

COMMISSIONER FIRESTONE: May I now

turn to your statement, paragraph 10 of the answer.

You say:

"The medical profession is concerned with the
total medical care of the total population on a
continuous basis."

Would you be good enough, Dr. Whitehead, to define total

medical care?

DR. MACKINNON: That means, sir, having

one, a doctor available to any patient for any illness
at all times, plus such help as he may need, such as the
availability of drugs, hospitals, transportation facilities



1 then say the definition you have just given to us is
2 also the definition for a comprehensive health care
3 programme for the people of New Brunswick?

4 DR. MacKINNON: I would say so.

5 COMMISSIONER FIRESTONE: Would you
6 care to explain to us what you mean by medical care
7 programme on a continuous basis?

8 DR. MacKINNON: Would you repeat
9 that please, sir?

10 COMMISSIONER FIRESTONE: What do you
11 mean by the word continuous?

12 DR. MacKINNON: By this we mean that
13 there should be a doctor available, and I am speaking
14 chiefly of doctors now, which is the emphasis of our
15 brief, for twenty-four hours a day, every day in the
16 year. That is what we would like to see continuously.

17 COMMISSIONER FIRESTONE: And this
18 coverage and service would be provided for all, those
19 that can afford to pay it and those who cannot afford to
20 pay it?

21 DR. MacKINNON: Yes, sir.

22 COMMISSIONER FIRESTONE: In the same
23 paragraph, you say that the doctor must assume any gap
24 between the offering and full medical attention. What
25 gap do you have in mind?

26 DR. MacKINNON: Certain insurance
27 programmes offer coverage for certain items. There are
28 probably none of them which are all-inclusive, that is
29 which would include such things as mileage for a country
30 call. If there is a gap between what the carrier will



DR. MACKINNON: I would say so.

COMMISSIONER FIRESTONE: Would you

care to explain to us what you mean by medical care

programme on a continuous basis?

DR. MACKINNON: Would you repeat

that please, sir?

COMMISSIONER FIRESTONE: What do you

mean by the word continuous?

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there should be a doctor available, and I am speaking

chiefly of doctors now, which is the emphasis of our

brief, for twenty-four hours a day, every day in the

year. That is what we would like to see continuously.

COMMISSIONER FIRESTONE: And this

coverage and service would be provided for all, those

that can afford to pay it and those who cannot afford to

pay it?

DR. MACKINNON: Yes, sir.

COMMISSIONER FIRESTONE: In the same

paragraph, you say that the doctor must assume any gap

between the offering and full medical attention. What

gap do you have in mind?

Programmes often coverages for certain items. There are

probably none of them which are all-inclusive, that is

all. If there is a gap between what the carrier will



1 pay for and what the patient needs, the doctor has to
2 see that that gap is closed. He has to provide the
3 service, whether there is payment by a carrier or not.

4 COMMISSIONER FIRESTONE: Well, that
5 is very helpful and noble. Thank you. May we turn now
6 to page 4, paragraph 3. You suggest when it comes to the
7 financing of the programme to make a distinction between
8 those that can afford to pay the premium, and those that
9 cannot afford the premium, and you recommend that the
10 overall prepaid medical care programme should be carried
11 out in the Province of New Brunswick through your prepaid
12 insurance plan, using the premium method to finance it.
13 We can be very brief on this point, because I think you
14 have answered in part the question before, but just to
15 restate the position, do I understand that you expect
16 those that can afford the premiums to pay the premiums,
17 and those who cannot afford the premiums to have them
18 paid by a government, provincial or municipal?

19 DR. WHITEHEAD: Correct.

20 COMMISSIONER FIRESTONE: And that
21 the funds which governments will be using to pay for this
22 will come from tax revenue?

23 DR. WHITEHEAD: That is right.

24 COMMISSIONER FIRESTONE: You are in
25 favour, therefore, of a comprehensive programme covering
26 everybody in the Province of New Brunswick. Now, we have
27 encountered in previous hearings some suggestion that if
28 there is a comprehensive programme in a province, whether
29 it is government financed or privately financed, or joint
30 financing just as you have in mind, that there is a

... gap is closed. He has to provide the

... whether there is payment of a certain or not.

... think you. May we turn now

to page 4, paragraph 3. You suggest when it comes to the

financing of the programme to make a distinction between

those that can afford to pay the premium and those that

cannot afford the premium, and you recommend that the

overhead premium be paid by the programme should be called

out in the Province of New Brunswick through your health

insurance plan, using the premium method to finance it.

We can be very brief on this point because I think you

have answered in past the question before, but, just to

restate the question, do I understand that you would

those that can afford the premium to pay the premium

and those who cannot afford the premium to have them

paid by a government, provincial or municipal?

DR. WHITMAN: Correct.

COMMISSIONER FLEMING: And that

the funds which governments will be using to pay for this

will come from tax revenues?

DR. WHITMAN: That is right.

COMMISSIONER FLEMING: You are in

favor, therefore, of a comprehensive programme covering

everybody in the Province of New Brunswick. Now, we have

mentioned in previous hearings some suggestion that

there is a comprehensive programme in a province, whether

... just as you have in mind, that



1 danger that people will mis-use such a programme through
2 overloading or over-utilization, mainly the result of
3 excessive service. Have you had any experience under
4 the medical care service plan now administered by the
5 Maritime Hospital Services Association of the mis-use of
6 of such a plan through over-servicing or overloading?

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1. If mis-use such a programme through

2. over-activation, mainly the result of

3. Have you had any experience under

4. of such a plan through over-activating or overloading?



1 DR. WHITEHEAD: From the medical side,
2 sir, I presume you are asking this question?

3 COMMISSIONER FIRESTONE: Correct.

4 DR. WHITEHEAD: I will try to answer
5 it from that side. We have had for some years now -- and
6 I have forgotten how many: five, six or eight -- a
7 reference committee which we ourselves select of reputable,
8 experienced doctors who are chosen by our executive
9 committee, and we give that committee free to the Blue
10 Shield for their use to refer any of these types of matters
11 which may arise. The doctor also has the other side of
12 the coin, that if he feels the plan is doing something
13 which he does not think is right, he may also refer it to
14 the reference committee, and the plan may do so also, and
15 so may the patient.

16 The same thing has been in existence
17 for many years in the operations of our compensation board.

18 I would say this with a certain degree
19 of satisfaction and perhaps pride, that the use made of
20 those reference committees is very small, and therefore,
21 I assume, and I think quite justly, that there is very,
22 very little over-servicing or the other word which you
23 used and which I have now forgotten.

24 COMMISSIONER FIRESTONE: Overloading.

25 DR. WHITEHEAD: Overloading; and if
26 there is, we have the mechanism set up to deal with it,
27 and we have not had to use it very much.

28 Also, we have two more: we have a
29 stated undertaking with the Blue Shield sponsoring it,
30 that our executive committee is available at any time to

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that our executive committee is available at any time to



1 them for the reference of matters of policy, and finally,
2 we have our Medical Council of New Brunswick which, under
3 the Medical Act, has a clause in it that any items such
4 as -- and perhaps Dr. Nugent could quote from memory --
5 anyway, there is a specific item in it that any charges
6 or items of any fraud, or anything of that nature, is
7 an offence under the Medical Act and may be dealt with by
8 the Department of Health.

9 The answer is that so far as we are
10 aware there is very, very little.

11 COMMISSIONER FIRESTONE: The point you
12 have made is that under your present experience there has
13 been very little of this overloading or over-utilization
14 or excessive servicing, and the few instances that have
15 occurred, you have got the mechanism to deal with it.
16 Let us assume that you would have a comprehensive programme
17 covering everybody in the Province of New Brunswick along
18 the lines you have suggested earlier, and which is con-
19 tained in your brief: would that same principle hold,
20 in your opinion?

21 DR. WHITEHEAD: Yes, sir, very definitely.

22 COMMISSIONER FIRESTONE: Would that
23 same principle hold if that scheme were wholly government
24 financed?

25 DR. McINERNEY: In answer to your
26 question directly, I don't think there would be a
27 deliberate attempt to fraud, but I think the tendency from
28 past experience would be that there would be more of an
29 effort or more policing required in order to prevent over-
30 utilization under a government scheme.



them for the reference of matters of policy, and finally, we have our Medical Council of New Brunswick which, under the Medical Act, has a clause in it that any items such as -- and perhaps Dr. Nugent could quote from memory -- anyway, there is a specific item in it that any charges or items of any kind, or anything of that nature, is an offence under the Medical Act and may be dealt with by the Department of Health.

The answer is that so far as we are aware there is very, very little.

COMMISSIONER RIVINGTON: The point you have made is that under your present experience there has been very little of this overloading or over-utilization or excessive servicing, and the few instances that have occurred, you have got the mechanism to deal with it. Let us assume that you would have a comprehensive program covering everybody in the Province of New Brunswick along the lines you have suggested earlier, and which is retained in your brief: would that same principle hold, in your opinion?

DR. WHITEHEAD: Yes, sir, very definitely. COMMISSIONER RIVINGTON: Would that same principle hold if that scheme were wholly government?

MR. McLENNERY: In answer to your question directly, I don't think there would be a deliberate attempt to fraud, but I think the tendency toward



1 COMMISSIONER FIRESTONE: Well, I would
2 like to pursue this a little so that the Commission
3 understands why doctors are likely to prescribe more or
4 are likely to over extend services if a scheme were
5 operated by government alone rather than a scheme where
6 private groups and government co-operate together, and
7 I would like to deal with just basic principles, if I may.

8 To agree to over extension it requires
9 agreement by two parties, the patient and the physician.
10 The physician has to agree to see the patient more often
11 than it is necessary, or, if we have a comprehensive
12 programme, to prescribe more drugs than are necessary to
13 regain health, and to order diagnostic services covered
14 under the Hospital Insurance Plan, like x-rays and
15 laboratory tests beyond what is required as a result of
16 good practice. Would you think that doctors are likely
17 to change their practice in this direction if the programme
18 were wholly government financed and sponsored if they
19 haven't been doing it in the past? Why should they all
20 of a sudden offer an over extension of service?

21 DR. McINERNEY: I don't think that the
22 profession as such would deliberately go to over-utiliza-
23 tion. However, the factor that enters into the picture is
24 that, human nature being what it is, the pressure upon
25 the doctor to over-utilize a service would be much, much
26 greater, and to just what extent the medical profession
27 would be able to offset that would be a big question mark.

28 THE CHAIRMAN: Pressure from which
29 direction, Doctor?

30 DR. McINERNEY: From the patient.



like to know this a little as to what the Commission
understandably doctors are likely to prescribe more or
are likely to over-extend services if a scheme were
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would be able to offset that would be a big question mark.

THE CHAIRMAN: Pressure from which

direction, Doctor?

DR. McINERNEY: From the patient.



1 COMMISSIONER FIRESTONE: Well, to
2 understand that pressure, would that pressure be for the
3 doctor to see the patient more often than required?
4 Would the patient say, if the doctor said, "Come back
5 next week", "No sir, I want to come back this week"?
6 Is that the sort of thing you would expect?

7 DR. McINERNEY: To go even possibly
8 a step further and say, "The government is paying for
9 this. I demand this. It is my right as a citizen to
10 have this service" -- even though in our opinion it is not
11 necessary as a practitioner.

12 COMMISSIONER FIRESTONE: If the
13 practitioner would take out of his drawer a statement of
14 regulations and read one paragraph which says he is
15 required to provide the medical services which are nece-
16 ssary to provide adequate health care in the opinion of
17 the physician, and if he were to read this paragraph, or
18 a pharaphrase of the paragraph to the patient, wouldn't
19 that be the answer?

20 DR. McINERNEY: It would if it would
21 relieve him of the pressure day after day and hour after
22 hour to provide the service.

23 COMMISSIONER FIRESTONE: I presume
24 doctors are under constant pressure and they have learned
25 to deal with it.

26 DR. MELANSON: Sir, may I add to that:
27 I submit that under those circumstances we would be en-
28 couraging floating. If you told an individual under those
29 circumstances that it would be advisable for him to come
30 back in two weeks, and the patient said, "I want to come



1 back in a week", and the doctor said, "It is not necessary;
2 I would rather not see you. You are abusing the plan",
3 that would encourage the patient to drift on to somebody
4 else, which they do anyway, frequently.

5 COMMISSIONER FIRESTONE: I presume
6 if that patient then goes to a second doctor, and he goes
7 through the same procedure and he gets the same answer,
8 and he tries a third doctor, in a fairly short period
9 he will run out of doctors in the neighbourhood and he
10 will have to travel certain distances, and after that he
11 will have to travel to other cities. While I can see
12 your point -- that it could happen -- there are certain
13 physical limitations to this floating arrangement. I am
14 not suggesting there will not be attempts made, but what
15 we are concerned with here is whether this would be a
16 serious obstacle to a comprehensive programme, and I want
17 to address the last question in this connection to Dr.
18 Whitehead again. You spoke, sir, of a mechanism that you
19 had to deal with some exceptional cases. If these cases
20 recur would you feel that mechanism would work even
21 though it would have to deal with a medical principle on
22 a comprehensive basis of covering all the people in the
23 country and in the province?

24 DR. WHITEHEAD: Yes, sir, the same
25 mechanism, I am sure, would be available and work. I wonder
26 if there is one thing that the panel has not said. We
27 have the definite feeling that under the system we have
28 now got where we are all sort of partners in this thing
29 that it has some definite advantages. The man working in
30 the mill, a member of a group of one hundred persons,



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4 else, which they do anyway, frequently.
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28 if there is one thing that the panel has not said, we
29 have the definite feeling that under the system we have
30 now got where we are all sort of partners in this thing
31 that it has some definite advantages. The new working is



1 subscribing to the Blue Shield for doctor's services and
2 so on, is under a sort of a feeling that he is part of
3 that one hundred, and if there is any real deliberate
4 mis-use on his part that actually that reflects on the
5 other ninety- nine persons in the group, and under the
6 thing we are talking about -- an overall government pro-
7 gramme -- whether these same factors would apply to the
8 same degree, I think, is doubtful.

9 COMMISSIONER FIRESTONE: May I now
10 turn to the question of financing of the programme, the
11 question that I think the doctors are very much interested
12 in, and I am sure everybody else concerned with medical
13 care service is interested in.

14 Just to restate my understanding of
15 the situation you have so far advanced, you have said
16 that you would expect that those that can afford to pay
17 would pay their premiums and those that cannot afford to
18 pay would have their premiums paid by the state. I think,
19 Doctor, this is a fair restatement of your position?

20 DR. WHITEHEAD: Yes.

21 COMMISSIONER FIRESTONE: Let us con-
22 sider the question of how these premiums could be termed.
23 I have given notice of this question to Dr. Whitehead
24 because I am proposing to quote a proposal that has been
25 submitted to us by the Medical Society of Prince Edward
26 Island in Charlottetown, and Dr. Whitehead was present
27 when the question was raised and he is familiar with
28 both the question and the answers we have received, but
29 we are interested in getting the views of the New
30 Brunswick Medical Society. If I may, Dr. Whitehead, just



...the ... of ...

mis-use on his part that actually that reflects on the other ninety-nine persons in the group, and under the thing we are talking about -- an overall government ...

same degree, I think, is doubtful

COMMISSIONER WINTERBORN: May I ...

turn to the question of financing of the program. The question that I think the doctors are very much interested in, and I am sure everybody else concerned with medical care service is interested in.

Just to restate my understanding of

the situation you have so far advanced, you have said that you would expect that those that can afford to pay would pay their premiums and those that cannot afford to pay would have their premiums paid by the state. I believe Doctor, this is a fair restatement of your position?

COMMISSIONER WINTERBORN: Let us ...

either the question of how these premiums could be formed. I have given notice of this question to Dr. Whitehead because I am proposing to quote a proposal that has been submitted to us by the Medical Society of Prince Edward Island in Charlottetown, and Dr. Whitehead was present when the question was raised and he is familiar with both the question and the answers we have received, but we are interested in getting the views of the New Medical Society. If I may, Dr. Whitehead, just



1 restate the question, perhaps I will do so by first
2 reading from paragraph 81 of the Prince Edward Island
3 Medical Association's submission:

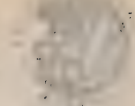
4 "Two alternative methods of financing of such a
5 plan are available",
6 and "such a plan" refers to a comprehensive medical care
7 programme covering all the citizens in a province.

8 "1. All persons of the community are pooled as
9 a single group risk, that is, all ages, the sick,
10 the well, the infirm and the uninsurable. A
11 community rate is struck for the total population.
12 We would favour this community rate method because
13 (a) it puts the burden where it belongs, on the
14 whole community,
15 (b) it obviates difficult classifications,
16 (c) it is simple to operate and cheaper to ad-
17 minister,
18 (d) it is now in use for the Hospital Service
19 Insurance Plan.

20 2. Alternatively the population is divided into
21 groups and each one is experience rate. This
22 makes premiums for certain categories prohibitively
23 expensive and does not spread risk adequately."

24 Dr. Whitehead, is the New Brunswick
25 Medical Society in favour of a rate to be struck on a
26 community basis covering the total population as a whole?

27 DR. WHITEHEAD: Mr. Chairman, we
28 spent quite a little while last night puzzling over this,
29 and our answer, sir, in at least the first stages is like
30 this: we feel -- and this is not critical of Prince



"Two alternative methods of financing of such a plan are available",

and "such a plan" refers to a comprehensive medical care programme covering all the citizens in a province.

"1. All persons of the community are pooled as a single group risk, that is, all ages, the sick, the well, the infirm and the uninsurable.

community rate is struck for the total population. We would favour this community rate method because

(a) it puts the burden where it belongs, on the whole community,

(b) it obviates difficult classifications,

(c) it is simple to operate and cheaper to administer,

(d) it is now in use for the Hospital Service Insurance Plan.

2. Alternatively the population is divided into groups and each one its experience rate. This makes premiums for certain categories prohibitively expensive and does not spread risk adequately."

Dr. Whitehead, is the New Brunswick Medical Society in favour of a rate to be struck on a community basis covering the total population as a whole?

DR. WHITEHEAD: Mr. Chairman, we spent quite a little while last night puzzling over this and our answer, sir, is at least the first answer is that



1 Edward Island's brief in any way -- that the idea of a
2 community rate is probably an ideal target. In this
3 province we have not, however, got to that stage and we
4 have not recommended that method of dealing with our
5 situation. We feel that the first thing that we should
6 do here is try to look after those who need help through
7 the plan we have just been talking about, that medical
8 care insurance should be made more available to the other
9 people more than it is now, and that they should pay for
10 it as they -- join if they wish; that is the key to it.
11 Those who decide they don't want to buy the insurance
12 have that privilege. We tried to delve into community
13 rates and all the ramifications thereof, and at the end
14 of two or three hours discussion we are still somewhat
15 going round and round. That is our position here as far
16 as we are concerned.

17 Your direct question was, I believe,
18 are we in favour of a community rate. I think the honest
19 answer at the moment is that we are not, because it is not
20 in our thinking and we have not had really an opportunity
21 as a group of sitting down and taking the thing apart
22 and taking a real good look at it.

23 COMMISSIONER FIRESTONE: Well, this
24 is an honest answer and I appreciate it. Would you be
25 prepared to consider the matter further in the light of
26 the questions that will be proceeding in a minute, and
27 then let us have your considered views at a later date?

28 DR. WHITEHEAD: Yes.

29 COMMISSIONER FIRESTONE: And just to
30 assist you in giving your considered views, I would like



1 ... it's tried in any way -- that the idea of a

2 ... is probably an ideal target. In this

3 ...

4 ... do here is try to look after those who need help enough

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6 ... care insurance should be made more available to the other

7 ... people more than it is now, and that they should say, "Now

8 ... it as they -- join if they wish; that is the way to do it."

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12 ... of two or three hours discussion we are still somewhat

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22 ... as an honest answer and I appreciate it. Would you be

23 ... prepared to consider the matter further in the light of

24 ... the questions that will be proceeding in a minute, and

25 ... then let us have your considered views at a later date?

26 ... assist you in giving your considered views, I would like



1 to pursue this question a little further: how are you
2 determining the rates at the present time under your plan?

3 MR. DOYLE: Mr. Chairman, our method
4 of projecting rates at the moment is probably in four
5 different classifications. First, we take all our firm
6 groups regardless of size and as if it were a community
7 rate. Those groups to that extent ----

8 COMMISSIONER FIRESTONE: So you have
9 a partial community rate already in effect?

10 MR. DOYLE: To the extent of payroll
11 groupings. We also have community rating to the extent
12 of direct pay subscribers. These subscribers pay one rate
13 regardless of age or utilization or whatever it may be.

14 COMMISSIONER FIRESTONE: So you have
15 already got two community rates?

16 MR. DOYLE: Right, sir. Now, the
17 third is that we have national rating where we join with
18 other plans across the country to enroll an experience
19 rate, a group on a national basis, and we also mutualize
20 our gains and losses. Some of these are operated on even
21 a retention basis where excess income is a matter for
22 refund. That is a form of pure experience rate and on a
23 national basis. Then we have some of our larger companies
24 in the Maritimes, and in this province, whereby we give
25 them a rate based on their experience. The rate based on
26 experience is not -- there are different forms of
27 experience rating, but the form we use is that the
28 succeeding year's rate is predicated on the past year's
29 experience.

30 COMMISSIONER FIRESTONE: Would you



...the rates at the present time under your plan?

of projecting rates at the moment is probably in fact
different classifications. First, we have all our
groups regardless of size and as if it were a community
rate. Those groups to that extent ----

COMMISSIONER WIRESTONE: Do you have
a partial community rate already in effect?

MR. DOYLE: To the extent of paying
groups. We also have community rating to the extent
of direct pay subscribers. These subscribers pay one rate
regardless of age or utilization or whatever it may be.
COMMISSIONER WIRESTONE: Do you have

already got two community rates?
MR. DOYLE: Right, sir. Now, the

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other plans across the country to enroll an experience
rate, a group on a national basis, and we also maintain
our gains and losses. Some of these are operated on even
a retention basis where excess income is a matter for
refund. That is a form of pure experience rate and on a

national basis. Then we have some of our larger companies
in the West, and in this province, whereby we give
them a rate based on their experience. The rate based on
experience is not -- there are different forms of
experience rating, but the form we use is that the
succeeding year's rate is predicated on the past year's

COMMISSIONER WIRESTONE: Would you



1 say that the bulk of the medical health care programme
2 which you are insuring -- the rates for this programme,
3 the bulk of that programme, is based already on a commun-
4 ity rate -- the bulk of the programme?

5 MR. DOYLE: To the extent I have
6 explained, very much so, sir.

7 COMMISSIONER FIRESTONE: May I pro-
8 ceed from the basis of where we are, Dr. Whitehead: we
9 have heard that you have already arrived for the bulk of
10 your subscribers at a community rate basis. Let us
11 assume this is extended to people aged over sixty years.
12 Would you think that your Society would favour that these
13 people, whose risks are greater, should pay a premium
14 applicable to that group only, which would be a consider-
15 ably higher premium, or would you feel that the community
16 as a whole should contribute to that rate and that the
17 rate should be struck on a community basis?

18 DR. WHITEHEAD: Again, sir, without
19 having the backing of my group in answering, I can answer
20 what I feel at the moment, and I presume this is part of
21 what you want us to explore further.

22

23

24

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26

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the bulk of the medical hospital care programme

the insurance -- the policy for the programme

MR. DOYLE: To the extent I have

explained, very much so, sir.

COMMISSIONER FIRESTONE: May I pro-

ceed from the basis of where we are, Dr. Whitbread?

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your subscribers at a community rate basis. Let us

assume this is extended to people aged over sixty years.

Would you think that your Society would favour that basis

people, whose risks are greater, should pay a premium

applicable to that group only, which would be a consider-

ably higher premium, or would you feel that the community

as a whole should contribute to that rate and what the

rate should be struck on a community basis?

DR. WHITBREAD: Again, sir, without

having the backing of my group in answering, I can answer

what I feel at the moment, and I presume this is part of

what you want us to explore further.



1 COMMISSIONER FIRESTONE: Yes. We
2 are just trying to be helpful and point out the consider-
3 ations which you wish to take into account.

4 DR. WHITEHEAD: This is all in the
5 transcript which we will get?

6 THE CHAIRMAN: The transcript will
7 be available to you. And I think I must say on behalf
8 of the Commissioner that you are not under an obligation
9 to make hazards or guesses if you want to give a
10 studied answer that will be of value to us.

11 DR. WHITEHEAD: Perhaps that would
12 be the way to do it.

13 COMMISSIONER FIRESTONE: I think this
14 is very helpful, and we are just giving you an indication
15 of the sort of recommendations which you wish to take
16 into account when giving a considered answer, and perhaps
17 you may like to bear in mind, Dr. Whitehead, and your
18 colleagues bear in mind, is what alternative do you have
19 in mind if you don't want to penalize the people who are
20 over-age or have peculiar conditions of health. There
21 are certain strong moral principles supporting this.

22 DR. MacDOUGALL: May I just point
23 out that in our discussions last night concerning this
24 point the other area which may be interjected here is
25 selective subsidy, which is also another method of obtain-
26 ing the same end, and this is one of the reasons why it
27 is difficult at the moment, without more study, to say
28 which one the Medical Society of the Province of New
29 Brunswick would be in favour of.

30 COMMISSIONER FIRESTONE: Well, we

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DR. MADDUCK: May I just point

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be available to you, and I think I must say on behalf

THE CHAIRMAN: The transcript will

transcript which we will get

DR. WHITEHEAD: This is all in the

to be helpful and point out the considerations



1 would appreciate if that sort of consideration would be
2 elaborated on in a supplementary submission, as long as
3 it deals with the basic problem we are facing. If you
4 want to provide for everybody in the province, how are
5 you going to pay for it?

6 Now, if I may turn to a point that
7 one of your members dealt with, and that is principle No.
8 5 in the statement of the C.M.A. on medical service
9 insurance, and if I may read that principle and then ask
10 questions on it.

11 "While there are certain aspects of medical
12 services in which tax-supported programmes are
13 necessary, a tax-supported comprehensive programme,
14 compulsory for all, is neither necessary nor
15 desirable."

16 I understand from the statement made previously that you
17 endorse this paragraph?

18 DR. WHITEHEAD: Yes.

19 COMMISSIONER FIRESTONE: Dr. Whitehead,
20 we again as a Commission are interested in the views of
21 the New Brunswick Medical Society, and we would like you
22 to explain in your own words this paragraph, this
23 principle which you endorse, and the first part of that
24 question is that you are not in favour of a tax-supported
25 comprehensive programme. Would you explain why you are
26 not in favour of a tax-supported comprehensive programme
27 in the light of the sort of explanation you have given
28 us earlier?

29 DR. WHITEHEAD: Mr. Chairman, we
30 had the advantage again of considering this last night,



11 that sort of consideration would be

12

13

14 want to provide for everybody in the province, how are

15 you going to pay for it?

16 Now, if I may turn to a point that

17 one of your members dealt with, and that is principle No.

18 in the statement of the C.M.A. on medical services

19 insurance, and if I may read that principle and then ask

20 questions on it.

21 "While there are certain aspects of medical

22 services in which tax-supported programmes are

23

24 compulsory for all, it is neither necessary nor

25 desirable."

26 I understand from the statement made previously that you

27 endorse this paragraph?

28

29 we again as a Commission are interested in the view of

30 the New Brunswick Medical Society, and we would like you

31 to explain in your own words this paragraph, this

32 principle which you endorse, and the first part of that

33 question is that you are not in favour of a tax-supported

34 comprehensive programme. Would you explain why you are

35 not in favour of a tax-supported comprehensive programme

36 in the light of the sort of explanation you have given

37 us earlier?

38

39 DR. WHITEHEAD: Mr. Chairman, we

40 have a advantage again or considering this last night,



1 and we feel that we have to, and we have always actually
2 read this whole paragraph as one piece, and as far as we
3 are concerned, the operative word in here is "compulsory"
4 for all. In our interpretation, I think we all agree,
5 that it is the compulsory aspect of it that we are not
6 in favour of.

7 COMMISSIONER FIRESTONE: In other
8 words, you are in favour of a tax-supported comprehensive
9 programme if it were not compulsory?

10 DR. MacDOUGALL: Mr. Chairman, for
11 the record, Professor Firestone has put in the record
12 that the medical profession are backing the principle of
13 tax-supported compulsory or are not in favour of a tax-
14 supported compulsory programme. This is the negative of
15 being in favour of the principle laid down there. I
16 would like to point out that we are in favour and may be
17 in favour of a tax-supported programme, not necessarily
18 throwing in the word "comprehensive". We are at the
19 present time backing a tax-supported programme for the
20 treatment of tuberculosis. It is compulsory for a patient
21 to go into an institution and be treated, and it is tax-
22 supported.

23 COMMISSIONER FIRESTONE: Thank you
24 for saying you are in favour of a tax-supported programme
25 compulsory for all.

26 DR. MacDOUGALL: I didn't say for all.

27 THE CHAIRMAN: He said for tubercu-
28 losis.

29 COMMISSIONER McCUTCHEON: And I
30 think that is because tuberculosis is an infectious disease



1 which must be kept under control just as venereal disease?

2 DR. MacDOUGALL: Yes. I point that
3 out that we are in favour of this in that instance.

4 COMMISSIONER FIRESTONE: Thank you
5 for your reply, only it doesn't answer my question. You
6 said that the objection, Dr. Whitehead, that you are
7 raising to this overall programme is that it is an overall
8 programme which is tax-supported and which is comprehen-
9 sive and which is compulsory for all.

10 Now, if it were compulsory, tax-
11 supported and comprehensive, would you be in favour, would
12 your association be in favour? Again, we would like to
13 leave it to your discretion to consider the matter further
14 and let us know your views at a later date. We are not
15 here to get a quick answer, we are here to get the con-
16 sidered views of your Society.

17 DR. WHITEHEAD: Yes, sir. May I say
18 something to that effect? It would be very much better
19 for us to do this, because the use of these words which we
20 have become accustomed to are just a little different when
21 interpreted by someone else who probably knows a great
22 deal more about it than we do, and we would certainly
23 like to have the opportunity of sitting down and mulling
24 it over and reviewing the record here and coming back
25 shortly.

26 COMMISSIONER FIRESTONE: That is very
27 helpful, Dr. Whitehead. You have indicated that you are
28 in favour of a comprehensive programme for the Province
29 of New Brunswick. You have also agreed that some of the
30 cost may be paid by government and the money coming from



DR. MACDONALD: Yes, I point that

out that we are in favour of this in that instance.

COMMISSIONER FIRESTONE: Thank you

for your reply, only it doesn't answer my question. You

said that the objection, Dr. Whitehead, that you are

raising to this overall programme is that it is an overall

programme which is tax-supported and which is comprehensive

and which is compulsory for all.

Now, if it were compulsory, tax-

supported and comprehensive, would you be in favour, would

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leave it to your discretion to consider the matter further

and let us know your views at a later date. We are not

here to get a quick answer, we are here to get the overall

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like to have the opportunity of sitting down and mulling

it over and reviewing the record here and coming back

COMMISSIONER FIRESTONE: That is very

helpful, Dr. Whitehead. You have indicated that you are

in favour of a comprehensive programme for the Province

of New Brunswick. You have also agreed that some of the

cost may be paid by government and the money coming from



1 taxes. So I understand that you have indicated your
2 support for a tax-supported comprehensive programme for
3 the province of New Brunswick, but you have not indicated
4 such support ~~on a~~ compulsory basis, you have indicated
5 support on a voluntary basis?

6 THE CHAIRMAN: I think we must bear
7 in mind what the gentleman said, that it is not for all
8 on the compulsory aspect.

9 COMMISSIONER FIRESTONE: If I may
10 pursue this question ----

11 THE CHAIRMAN: Certainly you may
12 pursue it, but I am just trying to put myself in the
13 position of the people who answer the questions so that
14 it will assist us and so that we understand what is being
15 driven at, so when we read the record we may have a full
16 appreciation of the value of the answers.

17 COMMISSIONER FIRESTONE: Thank you,
18 Mr. Chairman.

19 To continue, Dr. Whitehead, you have
20 indicated your support for a tax-supported comprehensive
21 programme, if my understanding of your earlier words,
22 your earlier statements were clearly understood. If they
23 are not clearly understood, please feel free to explain
24 in your subsequent written statement as the Chairman has
25 suggested.

26 I would like now to come to the
27 phrase "compulsory". Dr. Whitehead, you have in the
28 Province of New Brunswick a Hospital Insurance programme
29 in operation.

30 DR. WHITEHEAD: We have a hospital



support for a tax-supported comprehensive programme for
the province of New Brunswick, but you have not indicated
such support on a compulsory basis, you have indicated
support on a voluntary basis?

THE CHAIRMAN: I think we must begin

in mind what the gentleman said, that it is not for all
on the compulsory aspect.

COMMISSIONER FIRESTONE: If I may

pursue this question ---

THE CHAIRMAN: Certainly you may

pursue it, but I am just trying to put myself in the
position of the people who answer the questions so that
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indicated your support for a tax-supported comprehensive
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are not clearly understood, please feel free to explain
in your subsequent written statement as the Chairman has
suggested.

I would like now to come to the

phrase "compulsory". Dr. Whitehead, you have in the

Province of New Brunswick a Hospital Insurance programme
in operation.

DR. WHITEHEAD: We have a hospital



1 care plan, sir.

2 COMMISSIONER FIRESTONE: Yes, you
3 have a hospital care plan. Who is covered under that
4 hospital care plan?

5 DR. WHITEHEAD: Every resident of
6 the Province of New Brunswick.

7 COMMISSIONER FIRESTONE: Would you
8 tell us briefly how this plan is paid for? How is this
9 programme paid for?

10 DR. WHITEHEAD: Yes, sir. Without
11 knowing all the intimate details, it is financed now
12 through direct expenditures by the Government of the
13 Province of New Brunswick.

14 COMMISSIONER FIRESTONE: And how are
15 those expenditures financed? Are you familiar? Is it
16 financed through sales tax or what?

17 DR. WHITEHEAD: I would prefer very
18 much if one of the members of the Department of Health
19 or someone who is a little familiar with that to answer
20 where this money comes from.

21 DR. KELLY: Mr. Chairman, to put
22 it in a few words, it is financed from the consolidated
23 revenue of the province. Now, as I understand it, this
24 may be taxes from any source of any taxation from the
25 province. There are no taxes ear-marked at the moment,
26 and a certain percentage, as you know, is recovered from
27 the Government of Canada.

28 COMMISSIONER FIRESTONE: In other
29 words, the hospital care programme of New Brunswick is
30 financed out of the receipt of taxes.



care plan, sir.

COMMISSIONER FIRESTONE: Yes, you

have a hospital care plan. Who is covered under that

DR. WHITEHEAD: Every resident of

the Province of New Brunswick.

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tell us briefly how this plan is paid for? How is this

programme paid for?

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knowing all the intimate details, it is financed now

through direct expenditures by the Government of the

Province of New Brunswick.

COMMISSIONER FIRESTONE: And how is

those expenditures financed? Are you familiar with it?

financed through sales tax or what?

DR. WHITEHEAD: I would prefer not

much if one of the members of the Department of Health

or someone who is a little familiar with that to answer

where this money comes from.

DR. KELLY: Mr. Chairman, to put

it in a few words, it is financed from the consolidated

revenue of the province. Now, as I understand it, this

may be taxes from any source of any taxation from the

province. There are no taxes ear-marked at the moment.

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words, the hospital care programme of New Brunswick is

financed out of the receipt of taxes.

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Now, sir, is your association in

favour of this plan?

DR. WHITEHEAD: Of the hospital

plan itself?

DR. WHITEHEAD: Yes, we have been in

favour of the Hospital Insurance Plan from the beginning

and as it is now.

COMMISSIONER FIRESTONE: And this

plan being financed out of taxes is therefore covering

everybody and is compulsory; is that correct?

DR. WHITEHEAD: Yes, it is compulsory

-- every resident in New Brunswick is covered whether he

wants it or not.

DR. KELLY: It is not compulsory.

He has to contribute, but he doesn't have to use it. He

may pay his own way if he wishes, but this is not the

usual procedure. It doesn't cover individual residents

of the province who are covered by provincial and federal

acts, and neither does it cover residents of the province

until they are here for three months.

those exceptions, the bulk of the population are covered

whether they like it or not?

DR. KELLY: Yes.

a scheme that people belong to and you endorse in the

hospital field that covers all. If you are in favour of

this principle being applicable to hospital care, why are

you objecting to the same principle being applicable to



1 medical care? Again if you wish, please consider the
2 matter carefully. There is no need to give an off-hand
3 answer.

4 DR. WHITEHEAD: We would much prefer
5 to consider it.

6 COMMISSIONER FIRESTONE: Thank you
7 very much. This would be entirely satisfactory.

8 We now turn to page IV of your brief.
9 You say in paragraph 3 that essential drugs for these
10 groups be provided. Do I understand that the words
11 "essential drugs" mean drugs prescribed by physicians?

12 DR. WHITEHEAD: Yes, sir.

13 COMMISSIONER FIRESTONE: Thank you.

14 Paragraph 5 on the same page, you say:

15 "That a greater degree of supervision by the
16 Provincial Government or other Regulatory Body
17 be applied to the sale of Medical Care Insurance
18 in this province."

19 Does this mean that you are in favour of greater control
20 of, one, voluntary plans such as the Maritime Hospital
21 Services Association, and two, plans by commercial
22 carriers?

23 DR. WHITEHEAD: Yes.

24 COMMISSIONER FIRESTONE: Thank you.

25 The next question relates to paragraph 8 on page IV. You
26 say:

27 "That remuneration and terms of service for
28 doctors in employ of Government be placed on a
29 much more competitive basis...."

30 By "competitive basis" do you mean higher salaries to be



There is no need to give an off-hand

DR. WHITEHEAD: We would much prefer

COMMISSIONER FINESTONE: Thank you

very much. This would be entirely satisfactory.

We now turn to page IV of your brief.

You say in paragraph 3 that essential drugs for these

groups be provided. Do I understand that the words

"essential drugs" mean drugs prescribed by physicians?

DR. WHITEHEAD: Yes, sir.

Paragraph 5 on the same page, you say:

"That a greater degree of supervision by the

Provincial Government or other regulatory body

be applied to the sale of Medical Care Products

in this province."

Does this mean that you are in favor of greater control

of one, voluntary plans such as the Maritime Hospital

Services Association, and two, plans by commercial

DR. WHITEHEAD: Yes.

The next question relates to paragraph 8 on page IV. You

"That remuneration and terms of service for

doctors in employ of Government be placed on a

much more competitive basis...."



1 more in line with those paid in other provinces?

2 DR. WHITEHEAD: Yes, sir. But not
3 only the salaries. Apparently in some institutions at
4 least the terms of service, the authority and chain of
5 command and all these things are not as satisfactory perhaps
6 as they could be. So we have put the two things together,
7 the terms of service and remuneration factor together, sir.

8 COMMISSIONER FIRESTONE: Paragraph 9:

9 "That more planned research be undertaken"

10 Have you any specific proposal, one, as to the type of
11 research, and two, how to get doctors to undertake such
12 research? If you wish to let us have the answer in writing
13 at a subsequent date, that would be satisfactory.

14 DR. WHITEHEAD: We would like to study
15 that, sir.

16 COMMISSIONER FIRESTONE: Thank you very
17 much. May I now turn to page 21 of your submission in
18 which you cover drugs. You say here in paragraph 40 that
19 the Government of the Province of New Brunswick spent
20 about 1.3 million dollars on drugs from public funds.
21 These drugs, I take, were prescribed by qualified medical
22 doctors?

23 DR. WHITEHEAD: Yes. Actually, sir,
24 this paragraph is information which came at our request
25 from the Department of Health. Could we ask those questions
26 of Dr. Kelly?

27 DR. KELLY: Yes, sir, this is correct.
28 The drugs are all prescribed by qualified medical doctors,
29 qualified practising doctors.

30 COMMISSIONER FIRESTONE: Have you any



with those paid in other provinces?

DR. WHITEHEAD: Yes, sir. But not

the same amount. The amount paid in other provinces is

less than the amount paid in this province.

It is not the same amount, but it is

as they could be. So we have put the two things together,

the terms of service and remuneration together, and

COMMISSIONER FIRESTONE: Paragraph 2

"that more planned research be undertaken"

Have you any specific proposal, one, as to the type of

research, and two, how to get doctors to undertake such

research? If you wish to let us have the answer in writing,

at a subsequent date, that would be satisfactory.

DR. WHITEHEAD: We would like to state

that, sir.

COMMISSIONER FIRESTONE: Thank you very

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the Government of the Province of New Brunswick spent

about 1.3 million dollars on drugs from public funds.

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DR. WHITEHEAD: Yes. Actually, sir,

this paragraph is information which came at our request

from the Department of Health. Could we ask those questions

of Dr. Kelly?

The drugs are all prescribed by qualified medical doctors,

qualified practicing doctors.

COMMISSIONER FIRESTONE: Have you any



1 evidence of over-utilization?

2 DR. KELLY: No, sir.

3 COMMISSIONER FIRESTONE: You have no
4 evidence of over-utilization?

5 DR. KELLY: Because the main portion
6 of these were used in hospitals.

7 COMMISSIONER FIRESTONE: Dr. Whitehead,
8 is the New Brunswick Medical Society in favour of a pre-
9 paid drug plan for drugs prescribed by physicians?

10 DR. WHITEHEAD: Yes, sir, we would
11 be in favour of such a plan. Again, I think we should say
12 that actually we have talked about this from time to time,
13 and we feel it is not really our province to develop such
14 a plan, but we have no objection to it whatsoever in
15 principle.

16 COMMISSIONER FIRESTONE: If such a
17 plan were developed, would you prefer to see this plan as
18 part of a comprehensive medical care plan, or would you
19 like to see it administered separately?

20 DR. WHITEHEAD: We would feel that
21 drug costs and all other costs can be segregated and be
22 kept separately.

23 COMMISSIONER FIRESTONE: Do you feel
24 that some of the principles which you have recommended
25 for the payment, for the pre-payment of medical care should
26 also be applicable to a prepaid medical drug plan?

27 DR. WHITEHEAD: Yes.

28 COMMISSIONER FIRESTONE: If there
29 existed a comprehensive plan of medical care in New
30 Brunswick, including prepaid drugs, would you expect

COMMISSIONER FIRESTONE: You have no

evidence of over-utilization?

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1 substantial over-utilization of the plan through prescrip-
2 tion of drugs by physicians not required by the patient?



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1 DR. MELANSON: Mr. Chairman, no, I
2 don't think so, sir. In the majority of in-patient
3 prescriptions there is a definite stop order that is
4 governed by the staff and the majority of this item men-
5 tioned in section 40 does concern in-hospital care. In
6 the rank and file of the general practitioner and the
7 specialists towards prescriptions, I think that the con-
8 scientious physician is very cognizant of the cost of drugs
9 to the patient, and I think he would be just as consider-
10 ate in the utilization if there was a common carrier.

11 COMMISSIONER FIRESTONE: So you would
12 not expect serious over-utilization under a prepaid drug
13 plan?

14 DR. MELANSON: I wouldn't think so.

15 COMMISSIONER McCUTCHEON: Of course,
16 you have had no experience of such a plan, Doctor?

17 DR. MELANSON: Very true, no.

18 COMMISSIONER FIRESTONE: We might
19 be able to proceed further. You are basing the answer to
20 my question on the fact that drugs are prescribed by
21 doctors, and therefore, if there is a prepaid drug plan
22 covering only drugs prescribed by doctors, you are basing
23 your answer on your understanding of medical practice,
24 and you know that physicians will not prescribe, from your
25 own experience and that of your colleagues, will not
26 prescribe drugs unnecessarily?

27 DR. MELANSON: Correct, sir.

28 COMMISSIONER FIRESTONE: So, therefore,
29 your answer was based on your experience as a medical
30 practitioner, and that of your colleagues?



don't think so, sir. In the majority of instances

the rank and file of the general practitioner and the

scientist physician is very cognizant of the cost of drugs

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COMMISSIONER MONTGOMERY: Or would

you have had no experience of such a plan, Doctor?

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DR. MELANSON: Correct, sir.

COMMISSIONER FIRESTONE: So, therefore

your answer was based on your experience as a medical



1 DR. MELANDSON: Yes, sir.

2 COMMISSIONER FIRESTONE: Thank you,
3 Doctor. Now, the suggestion has been made by some that
4 when we have a free plan, and I am putting the free in
5 quotation marks, that people are likely to have the feel-
6 ing that they are going to get something for nothing, and
7 they will ask for more drugs than they require, and they
8 will get them. Now, there are two misconceptions in all
9 this talk about a "free" plan. One, first of all, that
10 in a prepaid plan that people pay for it either in
11 premiums or taxation, or a combination of the two, and
12 secondly, if the plan covers only doctor-prescribed drugs,
13 they can obtain these only if approved by a physician.
14 Would you say, sir, that if we had a comprehensive plan,
15 physicians would prescribe more drugs than are necessary?
16 Now, if I understand your answer earlier, the answer was
17 no. Would you still say no, in the light of the explan-
18 ation I have given you now under what some people call a
19 "free" plan?

20 DR. MELANSON: Well, sir, as long as
21 the prescription is in the hands of the physician, I don't
22 believe although we have no experience of it, I don't
23 believe that the doctor would be inclined to over prescribe,
24 regardless of the source from which the drugs would be
25 obtained.

26 COMMISSIONER FIRESTONE: Obtained and
27 financed?

28 DR. MELANSON: Yes.

29 COMMISSIONER FIRESTONE: To follow
30 this point up, if there were mis-use in some cases, nobody



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4 when we have a free plan, and I am putting the free in
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25 COMMISSIONER FLETCHER: Obtained and

26 DR. MELLANSON: Yes.

27 COMMISSIONER FLETCHER: To follow
28 this point up, if there were mis-use in some cases, nobody



1 is perfect I quite admit that, I presume that there would
2 be a mechanism by which doctors who are over prescribing
3 could be policed, or controlled, by the profession itself?

4 DR. WHITEHEAD: Yes, sir. I think
5 quite definitely that the same mechanism as is used for
6 other things could be used here.

7 COMMISSIONER FIRESTONE: Thank you,
8 that is a very definite answer. You have made a number
9 of recommendations in your submission. Would it be
10 possible in your subsequent written submission, Dr.
11 Whitehead, to let us know what these various proposals
12 would cost in terms of capital cost and operating cost,
13 and where would the money come from, according to your
14 views? There may be certain things you feel you cannot
15 put a dollar tag on it, and we will understand it, but
16 where you can it would certainly help us to know what it
17 would cost if some of the proposals which you have in
18 mind were to be implemented, and thank you very much,
19 Doctor, and your colleagues, for explaining to us the
20 principles which guide you.

21 COMMISSIONER McCUTCHEON: You have
22 referred many times to the mechanics by which the profession
23 looks at, shall we say, over-extension, or over-provision,
24 or over-utilization of services, by your Professional
25 Committee. Now, with whom does that Professional Committee
26 work, with the Maritime Hospital Services Association?

27 DR. WHITEHEAD: Yes, we have actually
28 one Reference Committee established for the work with the
29 Blue Shield, the Maritime Hospital Services Association,
30 and that same Committee is available if any matter of a



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1 similar nature should come up in private practice. A
2 person who is not covered under a plan, we can use that
3 same Committee to adjudicate if you wish, not adjudicate
4 it is the wrong word, to examine and give its opinion.

5 COMMISSIONER McCUTCHEON: Let us take
6 your Committee working with the Maritime Hospital Services
7 Association. The Maritime Hospital Services Association
8 is interested in both the providers of service and the
9 receivers of service?

10 DR. WHITEHEAD: Yes, sir.

11 COMMISSIONER McCUTCHEON: Let us take
12 the case of the physician you suggest has been over-
13 providing service, and the patient who says: "No, not only
14 has he not been over-providing service, I require all that
15 he gave me and I want something more". To whom does he
16 appeal?

17 DR. WHITEHEAD: The patient?

18 COMMISSIONER McCUTCHEON: Yes?

19 DR. WHITEHEAD: The patient has a
20 privilege of access to this Committee, either directly
21 through the plan, or through the Secretary of the Medical
22 Association, and he would state his complaint, whatever it
23 was, and he would be invited to come to the Committee
24 meeting and explain what his problem is, and the Committee
25 would examine it from his point of view, and the doctor's
26 point of view, and the plan's point of view, and give its
27 decision.

28 COMMISSIONER McCUTCHEON: Your mechanics
29 you say work very well up-to-date?

30 DR. WHITEHEAD: Yes.



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decision.

COMMISSIONER McCUTCHEON: Your words

you say work very well up-to-date?

DR. WHITEHEAD: Yes.



1 COMMISSIONER McCUTCHEON: Would they
2 work as well, Dr. Whitehead, in your opinion, if the
3 patient's appeal was to the local member of the legisla-
4 ture, or the local member of parliament, under one of
5 these highly tax-supported schemes that have been discussed
6 earlier today?

7 DR. WHITEHEAD: I have not thought of
8 that angle, sir. I don't think it would work as well,
9 because it wouldn't necessarily follow that that gentleman
10 who was elected to represent the community would really
11 have very much understanding of the situation.

12 COMMISSIONER McCUTCHEON: Thank you.
13 There was a suggestion made that you could prevent over-
14 utilization of service by drawing out of your drawer a
15 statement as to what you were to do under one of these
16 so-called free systems. Would you be in favour of having
17 your professional skill, the procedures and operations
18 which are performed, set down in a set of rules promulgated
19 by government?

20 DR. McINERNEY: No, definitely not.

21 COMMISSIONER McCUTCHEON: The Maritime
22 Hospital Services Association covers, I believe, about
23 14 per cent of the people in the province?

24 DR. MELANSON: Twenty-four per cent.

25 COMMISSIONER McCUTCHEON: And private
26 carriers about twelve. All right, 36 to 37 per cent.
27 Are there people outside that group who pay their bills?

28 DR. WHITEHEAD: Yes, sir.

29 COMMISSIONER McCUTCHEON: And you are
30 in favour, I take it, of allowing those people to pay



work as well, Dr. Whitehead, in your opinion, if the patient's appeal was to the local member of the legislature, or the local member of parliament, under one of these highly tax-supported schemes that have been discussed earlier today?

DR. WHITEHEAD: I have not thought of that angle, sir. I don't think it would work as well, because it wouldn't necessarily follow that that gentleman who was elected to represent the community would really have very much understanding of the situation.

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Are there people outside that group who pay their bills?

DR. WHITEHEAD: Yes, sir.

COMMISSIONER McCUTCHEN: And you are



1 their bills?

2 DR. WHITEHEAD: Yes, sir.

3 COMMISSIONER McCUTCHEON: Something
4 was said about continuous, twenty-four hours a day service,
5 three hundred and sixty-five days a year, available to the
6 patient. Now, I would refer you to the section, to the
7 item in the terms of reference that has been quoted before,
8 that the Commission, there is nothing in this about
9 comprehensive, that the Commission is to make recommen-
10 dations, recommend such measures as the Commissioners
11 believe will ensure that the best possible health care
12 is available to all Canadians. Do you believe that in
13 Canada it is possible to provide continuous twenty-four
14 hours a day service, three hundred and sixty-five days
15 of the year, to all Canadians? By possible I mean say
16 practical?

17 DR. MacKINNON: I think that is an
18 ideal that should be aimed at. It is not presently
19 possible.

20 COMMISSIONER McCUTCHEON: Thank you
21 very much. Now, on page 4 of your brief you state, these
22 are your recommendations:

23 "That a new prepaid insurance plan for medically
24 indigent persons, and other persons currently
25 uninsurable, be developed through the cooperation
26 of the Provincial Government, Municipalities,
27 Medical Society, and Blue Shield, and that it be
28 operated by the Blue Shield using the premium
29 method to finance it."

30 And I think you went on to indicate that the medically



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DR. MACKINNON: I think that is an

practical?

of the year, to all Canadians? By possible I mean any

there is no doubt that the Commission has

some of the most important recommendations

in the Commission's report, and I think that

recommendations, recommend such measures as the Commissioners

that the Commission, there is nothing in this about

item in the terms of reference that has been quoted before

patient. Now, I would refer you to the section, to the



1 indigent people at least, and those in the uninsurable
2 group, who cannot pay their own premiums, your suggestion
3 is that the government might pay those premiums.

4 "That essential drugs for these groups be provided.
5 That prepaid medical care insurance for those
6 groups who are not now covered and who are not
7 medically indigent, be made more available to
8 individuals through correlated efforts of all
9 parties concerned".

10 And that, I assume, would be that the Maritime Hospital
11 Services Association might improve its sales promotion and
12 so on. Is that still your position?

13 DR. WHITEHEAD: Yes.

14 COMMISSIONER McCUTCHEON: Thank you
15 very much.

16 DR. WHITEHEAD: Should I add though,
17 sir, I think we said this earlier, but I am just wondering
18 if I am missing a part of your question. Not to the
19 exclusion of M.H.S.A.

20 COMMISSIONER McCUTCHEON: With that
21 qualification, that is still your position after all this
22 two hours and a half discussion?

23 DR. WHITEHEAD: Yes.

24 COMMISSIONER McCUTCHEON: Thank you
25 very much. So what you are anxious to have in this
26 province is the best possible medical care for people,
27 consistent with the realities of the situation?

28 DR. WHITEHEAD: Yes.

29 COMMISSIONER McCUTCHEON: And while
30 you have made a number of recommendations, you have also



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COMMISSIONER McCUTCHEN: And while

have made a number of recommendations, you have also



Whitehead

1 listed some priorities, and I would like to refer to those
2 on page 31. The first priority is to the provision of
3 sufficient chronic and convalescent beds and rehabilitation
4 facilities and the supply of necessary personnel to man
5 all types of hospital accommodation. I take it that is
6 medical and para-medical personnel, and the section
7 follows on:

8 "..... to the development of all means of in-
9 creasing the numbers of suitable candidates
10 entering the study of medicine, to the encourage-
11 ment of qualified doctors to remain in New
12 Brunswick, and to the encouragement of doctors to
13 locate in those areas which are not now sufficien-
14 tly supplied; and also to the provision of pre-
15 paid medical care insurance to those groups of
16 the population not now covered."

17 Coming to the last clause first, also to the provision
18 of prepaid medical care insurance to those groups of the
19 population not now provided, that I take it is what you
20 mean?

21 THE CHAIRMAN: Not now covered I
22 think is the expression.

23 COMMISSIONER McCUTCHEON: Not now
24 covered. That I take it is your recommendation on pages
25 3 and 4 in Roman Numerals?

26 DR. WHITEHEAD: Yes.

27 COMMISSIONER McCUTCHEON: In other
28 words, you will make it available to the indigent and the
29 presently uninsurable, and you will hope that steps will
30 be taken so that either through Maritime Hospital Services



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presently uninsurable, and you will hope that steps will
be taken so that either through Maritime Hospital Service



1 Association, or other carriers, more people will be
2 encouraged to insure in a prepaid plan?

3 DR. WHITEHEAD: Yes.

4 COMMISSIONER McCUTCHEON: Then having
5 said that, you are saying that the most important things
6 are the provisions of these additional facilities, which
7 I think were referred to in the brief of the Health
8 Department yesterday, and to the provision of more medical
9 and para-medical personnel?

10 DR. WHITEHEAD: Yes.

11 COMMISSIONER McCUTCHEON: And assuming
12 that you don't reach Utopia overnight, it is the view of
13 your Association that those are the first two things that
14 should be concentrated on?

15 DR. WHITEHEAD: Correct, yes sir.

16 THE CHAIRMAN: Thank you very much,
17 gentlemen.

18 DR. WHITEHEAD: Thank you, sir, and
19 the Commissioners for their courteous hearing.

20 THE CHAIRMAN: We will now have the
21 brief of the New Brunswick Association of Registered
22 Nurses.

23 --- A short recess.
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COMMISSIONER McCUTCHON: Then having

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THE CHAIRMAN: We will now have the

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A short recess.



THE CHAIRMAN: The New Brunswick

Association of Registered Nurses.

EXHIBIT NO. 44:

Submission of the New
Brunswick Association
of Registered Nurses.

SUBMISSION

of

THE NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES

APPEARANCES:

Miss K. MacLaggan, 1st Vice-President,

Miss L. Smith, President

Miss M. Archibald, Executive-Director

Miss J. Stephenson, Member.

MISS MacLAGGAN: Mr. Chief Justice,

Miss Girard, gentlemen, I am Katherine MacLaggan, registered Nurse, and on my right is Miss Lois Smith, President of the New Brunswick Association of Registered Nurses. On my left is Miss Muriel Archibald, Executive-Director of the Association; and on her left Miss Jane Stephenson, a member of our Association, and Director of Nursing at the St. John General Hospital.



THE CHAIRMAN: The New Brunswick

EXHIBIT NO. 44: Submission of the New Brunswick Association of Registered Nurses.

SUBMISSION

of

THE NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES

APPEARANCES:

Miss K. MacLagan, 1st Vice-President,

Miss L. Smith, President

Miss M. Archibald, Executive-Director

MISS MACLAGAN: Mr. Chief Justice,

Miss Girard, Gentlemen, I am Katherine MacLagan, regis-

tered Nurse, and on my right is Miss Lois Smith, President

of the New Brunswick Association of Registered Nurses.

On my left is Miss Muriel Archibald, Executive-Director of

the Association; and on her left Miss Jane Stephenson, a

member of our Association, and Director of Nursing at the

St. John General Hospital.



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INTRODUCTION

The New Brunswick Association of Registered Nurses appreciates the opportunity to have its story written in to the public record of this Royal Commission on Health Services. We appreciate too the vastness of the task with which the Commission members have been charged. We share with the Right Honourable the Prime Minister of Canada a confidence that you will discharge your task with skill and dispatch.

Many of the points in our brief are known by us to be controversial. We do not suppose that we have presented to you all the answers, or even the best answers. But what we have had to say has been a matter of conscience. Our thoughts, opinions and recommendations are presented in the hope that the people of our province can have from the present and future nurses of New Brunswick the best in service. What material benefits and spiritual satisfactions accrue to us from the realization of the best in nursing service are considered by us to be by-products.

Approval has been given by the executive of the New Brunswick Association of Registered Nurses to the contents of this brief. The nature of directives from the Royal Commission on Health Services precluded its presentation to our general membership in advance of presentation to the Commission.

However, the views expressed here have been, at one time or another during the past five years, openly expressed to and by the general member-



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1 ship.

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3 of which Presented by:

4 Katherine MacLaggan
5 1st Vice President, N.B.A.R.N.
6

7 Supported during the presentation by:

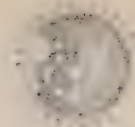
8 Miss Lois Smith
9 - President, N.B.A.R.N.

10 Miss Muriel Archibald
11 - Executive-Director, N.B.A.R.N.

12 Miss Jane Stephenson
13 - member, N.B.A.R.N.
14

15
16
17 The New Brunswick Association of
18 Registered Nurses,
19 231 Saunders Street,
20 Fredericton, N.B.

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27
28
29
30 November, 1961.



THE NEW BRUNSWICK ASSOCIATION OF

1907

MEMBERS

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2nd Vice President, N.B.A.R.N.

Miss Lois Smith

Miss Marie Archibald
- Executive-Director, N.B.A.R.N.

Miss Jane Stephenson
- member, N.B.A.R.N.

The New Brunswick Association of

231 Seaboard Street,
Frederickton, N.S.

November, 1907.

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SUMMARY

1. The Brief of the New Brunswick Association of Registered Nurses has hit at all facets of nursing. The terms of reference of the Royal Commission on Health Services have been broad enough to permit all-inclusive consideration.

2. We approached the preparation of our brief with two principles in mind:

1. standards of any service are dependent upon high standards of knowledge and skill;

2. nursing is essential to the maintenance and/or development of any health service.

3. In relation to the provision of any form or type of health service to the people of Canada and hence to the people of New Brunswick, we believe that the cost item to the individual should be removed from the free play of the price mechanism.

4. Some health services require priority action, to wit:

1. the inclusion of mental hospitals in the Hospital Insurance and Diagnostic Services Act;

2. the inclusion of Home Care, including nursing care, as an insured service.

5. The structure of nursing education and nursing service need priority action, to wit:

1. the number of students in professional schools of nursing in the university

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5. The structure of nursing education and nursing service need priority action, to wit:

1. the number of students in professional schools of nursing in the university

1 should be increased by eight to ten times
2 the present number.

- 3 2. a pattern of replacement for the hospital
4 school should be found so that technical
5 or clinical (or still-to-be named) nurses
6 can be prepared in sufficient number and
7 quality for their present and future role.
- 8 3. graduate programmes in our universities
9 should be developed rapidly, particularly
10 in the areas of administration so that
11 nursing will be qualified to teach
12 nursing.

13 6. Big decisions in nursing have to do with
14 structure; and the big decisions are not made by nurses
15 for nursing. This situation has created the most
16 dangerous single factor in the whole field of patient
17 care.

- 18 1. We recommend that the Royal Commission
19 on Health Services initiate a study of
20 the present status of nursing in our
21 culture.

22 7. The present situation with respect to
23 nursing could be immediately improved through legal
24 process. To this end we recommend:

- 25 1. that legislation pertaining to the
26 practice of nursing be made mandatory
27 rather than permissive;
- 28 2. that legislation pertaining to the
29 establishment and conduct of schools of
30 nursing which function outside the frame-



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1 work of general education be brought in
2 line so that there is no wastage in
3 human and physical resources.

4 8. We believe that basic nursing education be-
5 longs in educational institutions whose proper and
6 primary concern is education.

7 To this end we recommend

- 8 1. that schools of nursing be removed from
9 hospitals as soon as a pattern of re-
10 placement for the hospital school can
11 be found;
- 12 2. that an action research project be
13 undertaken in New Brunswick with the
14 purpose of finding the pattern of re-
15 placement for the hospital schools;
- 16 3. that such research be carried on under
17 the aegis of a university.

18 9. Until the change from hospital schools to
19 some other form is completed we recommend

- 20 1. that each school of nursing have a
21 qualified nurse-director or nurse-
22 principal, whose responsibility is
23 exclusively with the school;
- 24 2. that each school operate on a budget
25 which is separate and apart from the
26 nursing service;
- 27 3. that each school have its own board or
28 committee of management;
- 29 4. that living in residence not be a
30 requirement for admission to the school;

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1 5. that mandatory legal standards per-
2 taining to the conduct of these schools
3 be spelled out;

4 6. that no further capital investment from
5 the public treasury be made in hospital
6 schools of nursing.

7 10. We are convinced that no pattern of nursing
8 education, no matter how worthy, will work unless there
9 is a corresponding patterning of the nursing service
10 needs of the country. We therefore recommend

11 1. that the Royal Commission on Health
12 Services conduct a comprehensive enquiry
13 into and make recommendations on the
14 utilization of the services of all
15 categories of nurses in Canada.

16 11. Surely that which is "basic education" in
17 nursing refers to the base or the minimum on which a
18 service can be built. We believe that our society
19 can meet its nursing needs through the creation of two
20 groups of nurses, namely:

21 1. the professional nurse
22 2. the technical or clinical (or still-to-
23 be named) nurse.

24 When a pattern of replacement can be found for the
25 hospital school, we recommend.

26 1. that bursaries be made available by the
27 provincial government in amount and
28 number sufficient to remove any
29 financial impediment from the education
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of the technical or clinical (or clinical-



1 to-be named) student.

2 2. that all public institutions of higher
3 learning be tuition free.

4 12. We believe that the professional nurse
5 should be educated in the university. In order to
6 support the move of potentially professional people
7 to university programmes, we recommend

8 1. that a bursary system be established by
9 this province in amount and number
10 sufficient to remove any financial
11 impediment from the education of the
12 student.

13 In order to expedite the creation of new programmes in
14 nursing education, we recommend

15 2. that a crash programme be undertaken
16 through the professional training
17 grant system of the Department of Health
18 or through some other governmental
19 channel to qualify nurses to hold posts
20 on university faculties (and on faculties
21 for the education of our new nursing
22 group).

23 13. We believe that it is evident that some
24 institutionalization of educational efforts between the
25 high school and the university is needed for the post-
26 high school education of many of our citizens. And
27 nursing needs it in direct ratio to the expansion of
28 health services in Canada. We recommend

29 1. that the educational authority of this
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1 14. No one seems to know for sure how much public
2 money is presently being expended on nursing education in
3 New Brunswick. We believe that to know is in the public
4 interest. We recommend:

5 1. that the cost of the present system of nurs-
6 ing education be ascertained at the instiga-
7 tion of the Royal Commission on Health
8 Services.

9 Further, we ask the Royal Commission on
10 Health Services to:

11 2. ascertain what the costs of the nursing
12 education programs herein envisaged would be
13 to the State;

14 3. ascertain what proportion of the total
15 educational expenditure of the State should
16 be allocated to nursing.

17 15. It is withing the nature of our work that we not
18 only nurse the sick, but should, through a hierarchy of
19 organization, administer our own service. If efficiency
20 can be achieved through skilled administration, if
21 efficiency pertains to both human and physical facilities,
22 and if efficiency has both economic and humanistic values,
23 we recommend:

24 1. that an action research project in the
25 administration of the nursing services of
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1 16. We believe that the establishment of a provincial
2 advisory committee to the Department of Health on health
3 services would be in the public interest. We recommend:

4 1. that an advisory committee to the Department
5 of Health on health services be established;

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UNITED STATES DEPARTMENT OF HEALTH
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2. that the New Brunswick Association of Registered Nurses be represented on such a committee.

17. We believe that the value which society places on a given role should be reflected in the income gained from that role. We recommend

1. that nursing salaries be equated to the responsibility, service, preparation and status of the individual nurse.

Furthermore, we believe that organized nursing should seek out and exert reasonable control over remuneration, conditions of work, job security and tenure.

18. On the question of superannuation, we recommend

1. that pension systems, the cost of which to be borne by employer and employee, be made available to all nurses. (We urge support of the plan of the Canadian Nurses' Association).

2. that all pension systems in Canada be made portable.

19. In order to keep a fair proportion of our most able nurses in practitioner roles, we recommend

1. that there be no ceiling on the salary which a practitioner of nursing care can achieve.

20. Our government services discriminate against married women who work in terms of salary, tenure, superannuation and holiday time. To remove this archaic state of affairs, we recommend



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Since its inception in 1959 it has been supported in
part by the W. K. Kellogg Foundation, Battle Creek,
Michigan. This support ceases on June 30, 1962.

We recommend

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make permanent its Continuing Education
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PART I.

THE NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES

1. The New Brunswick Association of Registered Nurses, according to the 1957 Act of Incorporation, is "a body politic and corporate with perpetual succession and a common seal having all the powers of a company incorporated under the New Brunswick Companies Act."¹

2. The Association, which took its origin primarily from the Saint John Graduate Nurses' Association, was first incorporated on April 29, 1916, as the New Brunswick Association of Graduate Nurses. It is worthy of note that at that time the stated purpose of the organization was "for the protection of the public ... and that a certain measure of protection shall also be afforded to those nurses who duly qualify and register."

The present aims and objectives, as stated in the 1957 Act, are:

1. to assure qualified nursing care for the people of New Brunswick by improving and maintaining standards of nursing education and service;
2. to participate in nursing affairs which promote the public welfare;
3. to advance the professional and material welfare of its members, and welfare of nursing assistants.¹

3. Since the Association is affiliated with the Canadian Nurses' Association, it is able to maintain

¹ Act of Incorporation, 1957, New Brunswick Association of Registered Nurses

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1. The New Brunswick Association of Registered Nurses, according to the 1957 Act of Incorporation, is "a body politic and corporate with perpetual succession and a common seal having all the powers of a company incorporated under the New Brunswick Companies Act."

2. The Association, which took its origin primarily from the Saint John Graduate Nurses' Association, was first incorporated on April 29, 1913, as the New Brunswick Association of Graduate Nurses. It is worthy of note that at that time the stated purpose of the organization was "for the protection of the public ... and that a certain measure of protection shall also be afforded to those nurses who duly qualify and register."

The present aims and objectives, as stated

in the 1957 Act, are:

1. to assure qualified nursing care for the people of New Brunswick by improving and maintaining standards of nursing education and service;
2. to participate in nursing affairs which promote the public welfare;
3. to advance the professional and material welfare of its members, and welfare of nursing assistants.

3. Since the Association is affiliated with the

Canadian Nurses' Association, it is able to maintain

1 Act of Incorporation, 1957, New Brunswick

Association of Registered Nurses



1 direct contact with members of the nursing profession
2 throughout Canada. This, of course, facilitates the
3 realization of the aims and objectives.

4 4. One measure of the growth of the Association
5 is seen through the membership. At the time of the
6 first annual meeting there were four chapters. The
7 total membership was one hundred thirty-four.
8 As of September 30, 1961, there were ten chapters.
9 The total membership is three thousand, two hundred
10 thirty.

2,304	active
62	associate
864	non-active
<hr/> 3,230	total

13
14 plus 596 nursing assistants

15 (Appendices VI. & IX.)

16 5. The affairs of the Association are "under
17 the management of a Council representing all parts of
18 the province, not exceeding twenty-five in number."
19 Responsibilities relate to many matters affecting the
20 nursing profession including the requirement for ad-
21 mission to schools of nursing, the courses of in-
22 struction, examinations, registration, professional
23 disciplining of members, recommendation of personnel
24 policies, and also the education, training, qualifica-
25 tions, supervision, and registration of nursing assist-
26 ants.

27 6. The Association

28 1. has had the Act consolidated twice and
29 amended seven times in order to keep
30 abreast of ever-changing conditions - an

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total membership was one hundred thirty-four. As of September 30, 1961, there were ten chapters. The total membership is three thousand, two hundred

active	2,204
associate	82
non-active	84
total	<u>3,930</u>

(Appendices VI. & IX.)

5. The affairs of the Association are "under the management of a Council representing all parts of the province, not exceeding twenty-five in number." Responsibilities relate to many matters affecting the nursing profession including the recruitment for admission to schools of nursing, the courses of in-

disciplining of members, recommendation of personnel policies, and also the education, training, qualifications, supervision, and registration of nursing assistants.

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1. has had the Act consolidated twice and

amended seven times in order to keep

abreast of ever-changing conditions - an

1 example is apparent in a recent
2 amendment which provides for registration
3 of nursing assistants;

4 2. has continuously revised personnel
5 policies;

6 3. has continuously revised the minimal
7 standards for schools of nursing, first
8 proposed in 1924;

9 4. purchased its own building in 1957, where-
10 in it currently employs five full-time
11 and one part-time persons (it made this
12 purchase by selling shares to its own
13 members);

14 5. stimulated the study in nursing
15 education which resulted in the Russell
16 Report¹ (it should be noted that the actual
17 report was written under the auspices
18 of the University of New Brunswick);

19
20 ¹
21 Russell, Edith Kathleen, The Report of a Study of
22 Nursing Education in New Brunswick, Fredericton,
23 Canada, 1956, 8.

24 6. conducted five nursing institutes from
25 September 1957 until October 1958 (when,
26 as planned, these were taken over by
27 the University of New Brunswick) in the
28 manner recommended in the Russell
29 Report (see Appendix VII.);

30 7. has an Advisory Committee to the
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Nursing Education in New Brunswick, Fredericton, 1928

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7. has an Advisory Committee to the University of New Brunswick School of



1 Nursing on its Continuing Education
2 Program (see Appendix X.);

3 8. has an Advisory Committee on Nursing in
4 New Brunswick (a device through which
5 advice and support may be given to any
6 group or institution in the development
7 of programs pertaining to nursing in
8 New Brunswick) (see Appendix XI.);

9 9. plotted its course in 1957, following
10 the Russell Report of 1956, in its
11 Master Design for Nursing in New
12 Brunswick (see Appendix XII.);

13 10. speaks for nursing to governments, at
14 public hearings, at public assemblies,
15 and the like (see Appendix XIII.).

16 7. Thus it is maintained that not only because
17 of its legal responsibilities but also because of its
18 concern with the provision of nursing service in any
19 health scheme for our province, the New Brunswick
20 Association of Registered Nurses is the proper body to
21 speak on behalf of nurses in the Province of New
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PART II.

GENERAL STATEMENTS OF SOME BELIEFS OF THE
NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES

1. In relation to the provision of any form or type of health service to the people of Canada and hence to the people of New Brunswick, the New Brunswick Association of Registered Nurses believes that the cost item to the individual should be removed from the free play of the price mechanism.

2. Some health services require, in our opinion, priority action, to wit:

1. the inclusion of mental hospitals in the Hospital Insurance and Diagnostic Services Act;

2. the inclusion of Home Care, including nursing care, as insured services.

3. In order to begin to meet the nursing service needs in an expanded and comprehensive health service plan for our people, the total structure of nursing education and nursing administration needs priority action, to wit:

1. the number of students in professional schools of nursing in the university should be increased by eight to ten times the present number;

2. a pattern of replacement for the hospital school should be found so that technical or clinical (or still-to-be-named) nurses



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1. the number of students in professional schools of nursing in the university should be increased by eight to ten

2. a pattern of replacement for the hospital school should be found so that technical or clinical (or still-to-be-named) nurses



1 can be prepared in sufficient number and
2 quality for their present and future
3 role;

4 3. graduate programs in our universities
5 should be developed rapidly, particularly
6 in the area of administration, so that
7 nursing will be qualified to take over
8 the administration of nursing services
9 in all health agencies.



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PART III.

ON LEGISLATION

1. As ~~one~~ reads the Act of Incorporation 1957, one might assume that wide legal powers are conferred in standards of nursing service and nursing education. With such legal powers in hand one might conclude that what is wrong in nursing is the fault of the organized profession. To avoid such a conclusion, one must be careful to remember that legislation relates to the present structure of nursing. An analysis in depth soon establishes that all the big decisions in nursing have to do with structure; and the big decisions are not made by nurses for nursing. Part of the reason for this is that society has not offered to nurses the educational background so sorely needed for the conduct of affairs requiring big decisions. This situation has created the most dangerous single factor in the whole field of patient care.

2. Instead of offering opinions, which is all we have, for this state of affairs, we recommend

1. that the Royal Commission on Health Services initiate a study of the present status of nursing in our culture.

(We anticipate that such a study will have to involve an analysis on the status of women in our culture.)

3. Any legislation should be looked at for what it does not say as well as for what it says. We cite here two examples: the one of something that is

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cite here two examples: the one of something that is

1 said, and the other of something that is not said.
 2 1. In 1957 we asked the legislature of our
 3 province to require that hospital
 4 schools of nursing be operated in
 5 hospitals having not less than a daily
 6 average of one hundred (100) occupied
 7 beds. The legislation still reads
 8 "has a daily average of not less than
 9 fifty (50) occupied beds, or not having
 10 such daily "average was on the first
 11 day of January, 1949, an approved school
 12 of nursing under this Act."¹

13 This formula has a tremendous bearing on:
 14 a) the duplication of facilities, both
 15 human and physical;
 16 b) costs;
 17 c) quality of educational programs.
 18 (See Appendices I., I.-A, IV.-A, V.)

19 2. In 1961 we asked the legislature of
 20 the province to add to Section 10, sub-
 21 section 2, the clause: "The director
 22 of a school of nursing shall be a
 23 registered nurse."

24 This clause was protested by the New
 25 Brunswick Hospital Association, and hence lost. One of
 26 the arguments presented was that this would constitute
 27 a description of the type of person that the administra-
 28 tion of a hospital would have to employ. Or, as one
 29 person phrased it, a dictation on the part of nursing
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¹ Act of Incorporation 1957, New Brunswick Association
 of Registered Nurses, Section 10, sub-section 2(b), 8.



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1 to employers of nursing. From our point of view, we
2 were trying to insure by legal process that nursing
3 education would be under the direction of a nurse, in
4 the same sense that a law or medical or engineering
5 faculty is under the principalship or deanship of a
6 lawyer, a doctor, or an engineer. How can the
7 organized profession maintain and improve standards if
8 their attempts to spell out measurable and meaningful
9 standards are frustrated? We repeat - all the big
10 decisions in nursing have to do with structure, and the
11 big decisions are not being made by nurses for nursing.
12 The above examples, striking in principle if not in
13 fact, are cited to illustrate our point on decision-
14 making in nursing.

15 4. Change can be effected when the old order
16 accepts a more reasonable balance between the control
17 necessary from a higher authority and the power
18 necessary for nursing to maintain standards in nursing
19 education and hence in nursing service. A shift in
20 control and power can bring about change in the
21 structure of nursing. This means that education would
22 have to be the instrument of approach to the correction
23 of flaws in the structuring of nursing. And even then,
24 education for professional action can be a waste of
25 human effort if freedom to act is not the result. Old
26 authorities and old concepts of authority must change;
27 so must the laws which pertain to nursing.

28
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PART IV.

ON EDUCATION

1. Nursing education in our province is controlled, managed, and financed by hospitals (except for the School of Nursing at the University of New Brunswick). We note how small has been the contribution of the general education systems of Canada to nursing per se; but we also note the reluctance of the hospital system to support the thirty-year-old voice of nursing in its cry for the removal of nursing education from the hospital school. No matter how sweet the words of rationalization, the hospital school remains where it is because of the value of the service rendered by its students. This value is not alone, and possibly not at all, a financial one. One has only to ask two questions of 1960 records to establish the value of student nurse labour force. These are:

1. How many hours per week, compared to graduate nurses, are students "on duty"?

2. What is the ratio of graduate staff to student staff on evening and night duty? A controlled and stable labour force for patient care has an immediate value, even if a continuation of the present multiplies the problems of the future. All arguments for change should spring from one's philosophy of education. But the voice of nursing can no longer refrain from verbalizing that the holding onto of a system of education in order to fulfill a service need has a moral connotation, if not a legal one.

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1 2. The present pattern of nursing education in
2 the hospital school is a corruption of the principles
3 of Florence Nightingale. It is as erroneous to lay the
4 present state of affairs at her feet as it is to accord
5 to her the authorship or the philosophy of the Florence
6 Nightingale Pledge. The truth is that our present
7 pattern in hospital schools (as well as some universities
8 where the nursing education is in a separate block
9 controlled by the hospital) is primarily an expedient
10 of long standing, now firmly cemented in response to
11 service needs.

12 3. What would a change in the structure of
13 nursing education mean to the hospital in terms of
14 patient care? The difference would be in degree.
15 In nursing education, as in medical education, the
16 hospital would continue to make a tremendous con-
17 tribution. Students of nursing would have to be taken
18 into the clinical areas of the hospital to gain the
19 practical experience so necessary to their learning.
20 But service to the patient and hence to the health
21 agency would be a by-product of their education. And
22 the nurse-product of the new forms of education en-
23 visaged by this Association would, upon graduation, be
24 better able to improve the quality of patient care in
25 our present or future health services.

26 4. Care must be exercised to differentiate the
27 meaning in service needs of the hospital, nursing needs
28 of the patient, and educational needs of the student.
29 The service needs of the hospital are all-inclusive needs,
30



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4. Care must be exercised to differentiate the meaning in service needs of the hospital, nursing needs of the patient, and educational needs of the student.



1 and involve both professional and non-professional
2 workers of many types. A division in labour is
3 obviously necessary; specifically, nursing needs to
4 be divorced immediately from non-nursing duties. Even
5 with our present use of students of nursing in service
6 activities, one study¹ establishes that senior students
7 spend only 55% of their time in work performed by
8 staff nurses. The remaining 45% of activities are
9 replaceable by auxiliary or non-nurse workers. Think
10 of the implications here for the so-called shortage
11 of nurses. It is fair to offer the reminder that
12 there are categories of people other than nurses to
13 meet the service needs of hospitals.

14 5. Only nurses (i.e., nurses in the legal
15 sense) should meet the nursing needs of patients.
16 This principle has been so aborted by present day
17 practice that nurses have been almost removed from
18 the bedside of the patient. Frankly, nurses want
19 that patient back again. We think that the creation
20 of professional and technical or clinical (or still-
21 to-be-named) nurses will give the patient back to
22 nurses.

23 ¹ Robin F. Badgley, "The Cost and Scope of Ward
24 Activities of Student Nurses," Canadian Hospital,
25 September, 1961.

26 6. Meeting only the educational needs of the
27 student of nursing through experience in the clinical
28 areas will shorten drastically the time presently
29 devoted to nursing service needs. Nursing has already
30 made this point abundantly clear in its Windsor School



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2 7. At no place is the disharmony between
3 nursing education and nursing service more apparent than
4 when organized nursing tries to come to a collective
5 decision about the issuance of certificates of approval
6 to shaky schools of nursing. The conflict in values
7 (namely, the service needs of the hospital versus
8 the educational needs of the student) is so great
9 that no schools have ever been closed in this province
10 by our Association, even on the present standards of
11 evaluation.

12 8. In our case, the minimum educational re-
13 quirement for admission to a school of nursing is
14 successful completion of a matriculation or high
15 school graduation examination conducted by the Depart-
16 ment of Education or an educational standing sub-
17 stantially equivalent thereto. (see Appendices II. and
18 III.). At the moment forty-two students, or
19 approximately 5% are enrolled in our one university
20 school where the course leads to a baccalaureate
21 degree. The remainder attend hospital schools. We
22 suspect that those making 70% or over on departmental
23 examinations belong in professional schools of nursing,
24 and those lower than that belong in technical schools
25 of nursing.

26 9. We subscribe to the policies of the
27 Canadian Nurses' Association, and we interpret them

2

1

28 Lord, A.R. Report of the Evaluation of
29 the Metropolitan School of Nursing, Windsor,
30 Ontario, The Canadian Nurses' Association, 1952
2Educational Programs of National Organizations,



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8. In our case, the minimum educational requirement for admission to a school of nursing is successful completion of a matriculation or high school graduation examination conducted by the Department of Education or an educational standing substantially equivalent thereto. (see Appendixes II and III.) At the moment forty-two students, or approximately 2% are enrolled in our one university school where the course leads to a bachelors degree. The remainder attend hospital schools. We suspect that those making 70% or over on departmental examinations belong in professional schools of nursing, and those lower than that belong in technical schools of nursing.

9. We subscribe to the policies of the Canadian Nurses' Association, and we interpret these



Canadian Conference on Education, Ottawa.

as follows:

1. THAT THE ORGANIZED PROFESSION EXERCISE RESPONSIBILITY FOR SETTING AND MAINTAINING THE STANDARDS OF EDUCATION OF ITS MEMBERS.

a) Hedging the authority of nursing in any area of its responsibility creates conflict and frustration, resulting in stunted efforts. If the organized profession is to carry responsibility for the setting and maintaining of standards, then these standards should equate to the quality of nursing service needed by our people. As it is at the moment in our province, our standards must be geared to the present structure of nursing education. We cannot go beyond that base of accomplishment possible of achievement in a school of nursing attached to a fifty-bed or even smaller hospital (see Appendix I.). Neither can we go beyond that level of educational content which our nurse educators are capable of teaching (see Appendix V.).

b) Thus it is that an almost farcical situation exists, namely - the New Brunswick Association of Registered Nurses must devise, supervise, and



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that level of educational content which our nurse educators are capable of

teaching (see Appendix V.).

b) Thus it is that an almost fatal

attraction exists, namely - the New

Brunswick Association of Registered



1 maintain standards which fit a system
2 over which it has very little influence
3 and no control. Both the vested in-
4 terests of the hospital and the
5 helplessness of the New Brunswick
6 Association of Registered Nurses tend
7 to keep the present situation at a
8 needless and dangerous level of
9 mediocrity. Yet even now overnight
10 improvement could result. To the end
11 that reasonable improvement can be
12 instigated, we recommend:

- 13 1) that legislation pertaining to the
14 practice of nursing be made
15 mandatory rather than permissive;
- 16 2) that legislation pertaining to the
17 establishment and conduct of
18 schools of nursing which function
19 outside the framework of general
20 education be brought in line so
21 that there is no wastage in human
22 and physical resources.

23 2. THAT THE BASIC PREPARATION OF NURSES BE AN
24 EDUCATIONAL EXPERIENCE WHICH THE CANADIAN
25 NURSES' ASSOCIATION BELIEVES CAN BEST BE
26 ACHIEVED IF THE EDUCATION IS PLANNED AND
CONTROLLED IN ITS ENTIRETY BY THE SCHOOL
CONCERNED

- 27 a) The privilege of "planning and controlling"
28 the education of students is usually a
29 built-in right of the educational
30 institution concerned. Not so with

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terests of the hospital and the

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1 hospital schools, because the proper and
2 the primary purpose of the hospital is
3 to render service to its patients. We
4 believe that basic nursing education
5 belongs in an educational institution
6 whose proper and primary concern is
7 education. To this end, we recommend
8 that:

9 1) schools of nursing be removed
10 from hospitals as soon as a pattern
11 of replacement for the hospital
12 school can be found.

13 In order to expedite what this pattern
14 should be, we recommend that:

15 2) an action research project be under-
16 taken in New Brunswick with the
17 purpose of finding the pattern of
18 replacement for the hospital school.

19 Because such action research is exclusive-
20 ly concerned with education, we recommend
21 that:

22 3) such research be carried on under
23 the aegis of a university.

24 b) The New Brunswick Association of Re-
25 gistered Nurses recognizes that the
26 present dependence of our hospitals on
27 the services of students or nursing means
28 that any drastic change cannot jeopardize
29 the nursing care of patients (see
30 Appendices VIII. and VIII.-A). In other

1 words, the change to sounder forms of
2 nursing education must and can be effect-
3 ed with the minimum of impact on hospital
4 service needs. Until the change from
5 hospital schools to some other form is
6 completed, we recommend the following:

- 7 1) that each school of nursing have a
8 qualified nurse-director or nurse-
9 principal, whose responsibility is
10 exclusively with the school (by
11 qualified is meant registration, pro-
12 fessional and general education at
13 least to the baccalaureate level);
- 14 2) that each school operate on a budget
15 which is separate and apart from the
16 nursing service (see Appendix IV.);
- 17 3) that it have its own board or
18 committee of management;
- 19 4) that living in residence not be a
20 requirement for admission to the
21 school;
- 22 5) that mandatory legal standards
23 pertaining to the conduct of these
24 schools be spelled out;
- 25 6) that no further capital investment
26 from the public treasury be made in
27 hospital schools of nursing.

28 c) We are looking forward to the results of
29 the current study as projected by the
30 Canadian Nurses' Association on "the



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fessional and general education at
least to the baccalaureate level);

2) that each school operate on a budget
which is separate and apart from the
nursing service (see Appendix IV);

3) that it have its own board or
committee of management;

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prerequisite for admission to the
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5) that mandatory level standards
pertaining to the conduct of these
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the current study as projected by the

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Canada." Surely the results of this
study will give us a correct sense of
direction, if not an exact blueprint
for the future. We are convinced, how-
ever, that no blueprint, no matter how
worthy, will be permitted to work unless
the nursing service needs of the country
are also patterned. We, therefore,
recommend that:

- 1) the Royal Commission on Health
Services conduct a comprehensive
enquiry into, and make recommenda-
tions on the utilization of the
services of all categories of nurses
in Canada.
3. THAT BASIC NURSING EDUCATION BECOME A
PART OF THE GENERAL EDUCATIONAL SYSTEMS
OF CANADA.
 - a) One would think that the placement
of nursing education in the frame-
work of the general educational
systems of Canada would be easy of
accomplishment. So it would be if
all the thinkers on the problem
would clear their minds of the image
of a student nurse group as a
labour force. This seems to be as
difficult for our present education-
al administration to do as it is for
hospital administrations. However,



whole field of nursing education in Canada." Surely the results of this study will give us a correct sense of direction, if not an exact blueprint for the future. We are convinced, however, that no blueprint, no matter how worthy, will be permitted to work unless the nursing service needs of the country are also patterned. We, therefore,

1) the Royal Commission on Health Services conduct a comprehensive study into, and make recommendations on the utilization of the services of all categories of persons in Canada.

THAT BASIC NURSING EDUCATION BECOME A PART OF THE GENERAL EDUCATIONAL SYSTEM OF CANADA.

2) One would think that the placement of nursing education in the framework of the general educational systems of Canada would be easy of accomplishment. So it would be if all the thinkers on the problem would clear their minds of the image of a student nurse group as a labor force. This seems to be as difficult for our present educational administration to do as it is for



1 it must be admitted that some house
2 cleaning is in order in the nursing
3 family first. The sudden pro-
4 liferation in the types of people
5 employed in the name of nursing has
6 confused the organized profession as
7 much as the general public (see
8 Appendix VIII.). And the con-
9 fusion can be traced back to the
10 fact that expedience rather than
11 wisdom was the force at work.

12 b) Surely that which is "basic education"
13 refers to the base or minimum on
14 which a service can be built. We
15 believe that our society can meet
16 its nursing needs through the
17 creation of two groups of nurses,
18 namely:

- 19 1) the professional nurse; and
20 2) the technical or clinical or
21 still-to-be-named nurse.

22 c) Since we believe that two groups in
23 nursing are essential to the well-
24 being of the community, we must go
25 on to state that we believe the
26 education of one group must be
27 evolved with an eye on the other
28 group. Our first step must be to
29 differentiate the roles of these
30 two groups, as follows:



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family level. The sudden pro-
liferation in the types of people
employed in the home of nursing has
confused the organized profession as
much as the general public (see
Appendix VIII). And the con-
fusion can be traced back to the
fact that experience rather than
wisdom was the force at work.

c) Surely that which is "basic education"
refers to the care of mankind as
which a service can be built. We
believe that our society can meet
its nursing needs through the
creation of two groups of nurses,
namely:

- 1) the professional nurse; and
- 2) the technical or clinical ex-
act-to-be-named nurse.

e) Since we believe that two groups in
nursing are essential to the well-
being of the community, we must go
on to state that we believe the
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evolved with an eye on the other
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differentiate the roles of these
two groups, as follows:

6
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1) The professional nurse:

(a) provides skilled nursing care in the hospitals and other health services

by:

(1) performing complex functions requiring educated judgment and technical skill;

(2) making a nursing assessment of nursing care needs;

(3) preparing a nursing care plan;

(4) initiating the plan (including the judgment of what shall be delegated to the other group);

(5) adapting the plan to changing circumstances;

(6) evaluating the plan (in terms of quality of care and the administrative factors in achieving the quality of care);

(b) contributes to the decisions as to the type of institution in which the nursing service needed can best be rendered;

(c) performs to the level of team leader but through experience and education may progress to specialized activities, such as:

nurse-specialists in the clinical specialties (i.e., medical-surgical, paediatric, obstetric, and psychiatric nursing;

education;

administration;

consultation;

research;

(d) maintains a collaborative (as opposed



(e) provides skilled nursing care in the

hospitals and other health services

(1) performing complex functions

technical skills

(2) making a nursing assessment of

(3) preparing a nursing care plan;

(4) initiating the plan (including the judgment of what shall be delegated to the other group);

(5) adapting the plan to changing

(6) evaluating the plan (in terms

of quality of care and the administrative factors in achieving the quality of care);

(b) coordinated to the institution as to

the type of institution in which the

nursing service needed can best be

performance to the level of team nursing

but through experience and observation

such as:

physicians, nurses, medical and dental, pediatric, obstetric, and psychiatric services

coordination:



1 to a subordinate) relationship with
2 the physician and coordinates the
3 nursing care plan with the medical
4 care plan;

5 (e) maintains both a collaborate and
6 coordinating (where appropriate)
7 relationship with other health or
8 welfare workers;

9 (f) observes and reports effects of
10 medical therapy, making changes in
11 the nursing regime if indicated;

12 (g) interprets and demonstrates skilled
13 nursing care to others (i.e., others
14 in the nursing hierarchy);

15 (h) initiates or changes the nursing care
16 from the vantage of the principles
17 on which her knowledge is built;

18 (i) teaches the patient and/or his
19 family and/or the community what is
20 appropriate to the health situation;

21 (j) participates with members of the
22 health professions, community groups
23 and other professional people in
24 solving health problems in the
25 community;

26 (k) structures the emotional and
27 physical environment (assuming
28 sound administrative policies) so
29 that the maximum health of the in-
30 dividual or the group can be



the physician and coordinates the nursing care after with the medical

maintaining a collaborative and

relationship with other health or welfare workers;

(f) observes and reports effects of medical therapy, making changes in the nursing regime if indicated;

(g) interprets and demonstrates skilled nursing care to others (i.e., others in the nursing hierarchy);

(h) initiates or changes the nursing care from the vantage of the patient on which her knowledge is based;

(i) teaches the patient and/or his family and/or the community what is appropriate to the health situation;

(j) participates with members of the health profession, community groups and other professional people in solving health problems in the

(k) articulates the emotional and

sound administrative policies so that the maximum benefit of the individual or the group can be



achieved or maintained;

(1) understands and fulfils the pro-

fessional role of nursing by

- assuming responsibility for the
quality of service rendered;

- maintaining integrity in her many
relationships, and

- contributing to society in-
dividually and through her pro-
fessional organization;

(m) is educated for

- her own sake;

- the sake of society.

2. The technical or clinical (or still-to-
be named nurse:

(a) performs functions which involve

both judgment and skill, but these

functions will be carried on under

the supervision and direction of the

professional nurse (or, in the case

of medical therapy, under the

physician);

(b) assists the professional nurse through

observation and reporting in the

making of a nursing assessment of

needs, but is not responsible for

making this assessment herself;

(c) plans her assigned tasks but does

not prepare the nursing care plan;

(d) evaluates her own assignment but does

not evaluate the total nursing care

plan;

noted on the
the following
the following

essential role of nursing by

- assumed responsibility for the
quality of service rendered;

- maintaining integrity in her many
relationships; and

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(a) performs functions which involve

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the supervision and direction of the

professional nurse (or, in the case

of medical therapy, under the

physician);

(b) assists the professional nurse through

observation and reporting in the

making of a nursing assessment in

needs, but is not responsible for

(c) plans her assigned tasks but does

not evaluate the total nursing care



(e) functions from a body of knowledge which enables her to perform with safety the technical skills in patient care;

(f) performs to the level of the staff nurse, and through experience, in-service education, and the development of extraordinary technical skill may progress to highly specialized activities in health services (e.g., scrub-nurse in operating room, immunization techniques in public health clinics, work in nurseries, etc.);

(g) has full membership in organized nursing;

(h) is educated for

(1) her own sake;

(2) the good of society.

d) We have differentiated the roles of these two groups on the basis of labour (see above). We believe that there can be further differentiation on the following measurable standards:

1) the difference in entrance requirements;

2) mobility in the nursing hierarchy.

We now have two streams of entry to so-called professional nursing, the one direct to the university and the other to the hospital school. En-

acquired technical skills in

laboratory work.

service education, and the develop-

skill may progress to highly

specialized activities in health

services (e.g., nurse-practitioner

operating room, instrumentation

techniques in public health clinics

work in nurseries, etc.);

(g) has full membership in organized

nursing;

(h) is admitted to

(2) the good of society.

d) We have differentiated the roles of these

two groups on the basis of labor (see

above). We believe that there can be

further differentiation on the following

measurable standards:

1) the difference in entrance require-

ments;

2) mobility in the existing hierarchy.

We now have two streams of entry to the

called professional nursing, the one direct to the

university and the other to the hospital school. In-



1 trance requirements to the hospital school are lower
2 than to the university (see Appendix III.). Entrance
3 standards to our nursing assistant courses are still
4 lower. Yet already (i.e., since 1958) there is a
5 blurring of the line between our registered nurse group
6 from the hospital school and our registered nursing
7 assistant in terms of the function of each group. We
8 believe that these two groups should meld into one.
9 From this melding comes our new nurse. It is not so
10 easy to recommend where the education of this new nurse
11 belongs, beyond expressing the conviction that it belongs
12 in the general education (post high school level)
13 systems of Canada. These systems are themselves in
14 flux at the moment. Whether we are going on to de-
15 velop Junior College systems such as the Ryerson
16 Institute in Toronto, or something in between these
17 two, or something altogether new remains to be seen.
18 It is evident that some institutionalization of
19 educational efforts between the high school and the
20 university is needed by our society for the post high
21 school education of many of our citizens. And nursing
22 needs it in direct ratio to the expansion of health
23 services in Canada.

24 And when we get a pattern of replacement for
25 the hospital school, we recommend:

- 26 1. that bursaries be made available to the
27 provincial government in amount and number
28 sufficient to remove any financial impediment
29 from the education of the technical or
30 clinical (or still-to-be-named) student;



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blurring of the line between our registered nurse group

from the hospital school and our registered nursing

assistant in terms of the function of each group. We

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university is needed by our society for the post high

school education of many of our citizens. And nursing

needs it in direct ratio to the expansion of health

services in Canada.

And when we get a pattern of replacement for

the hospital school, we recommend:

1. that provision be made available to the

provincial government in amount and manner

sufficient to remove any financial impediments

from the creation of the technical or



2. that all institutions of higher learning be
tuition free.

4. THAT THE ASSOCIATION PROMOTE AN INCREASE
IN THE NUMBER OF STUDENTS ENTERING BASIC
NURSING COURSES AT UNIVERSITIES

a) We support the belief that the professional nurses should be educated in the university. We believe (on a judgment basis) that we should have one professional nurse for every four clinical or technical nurses. We have arrived at this ratio by observing that approximately 25% of the students who enter schools of nursing have demonstrated in their high school examination marks that they probably can achieve at the university level (see Appendix II.). The remainder could profit from a technical or vocational form of education. Add to this group the best of those students who presently enter other forms of nursing programs (see Appendix IX.-A) and you get approximately one to four.

(b) If society were giving 25% of the young women who currently choose nursing a professional education, the impact on quality and efficiency can be predicted to be very great. What the difference in cost between

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If society were giving 25% of the young women who currently choose nursing a professional education, the impact on quality and efficiency can be predicted to be very great. What the difference in cost between

the hospital school and the university school would be we cannot predict, but we are already spending money in both institutions (see Appendices IV. and IV.-B). In order to support the move of potentially professional people to university, we recommend:

1) that a bursary system be established by this province in amount and number sufficient to remove any financial impediment from the education of the student.

5. THAT IT ENCOURAGE THE DEVELOPMENT OF GRADUATE PROGRAMS IN NURSING (BOTH AT THE MASTER'S AND DOCTORAL LEVELS) AT CANADIAN UNIVERSITIES
6. THAT IT PROMOTE AN INCREASE IN THE NUMBERS OF SPECIALLY QUALIFIED NURSES TO TEACH, ADMINISTER, AND ACT AS CONSULTANTS AND RESEARCH WORKERS

The New Brunswick Association of Registered Nurses subscribes wholeheartedly to the above policies. In particular, we recommend:

a) that a crash program be undertaken through the professional training grant system of the Department of Health or through some other governmental channel to qualify nurses to hold posts in nursing on university faculties and on faculties for the education of our new nursing group. (At present, uni-



1 versity nurse-faculty members are
2 not eligible for professional train-
3 ing grants in the Province of New
4 Brunswick.)

- 5 7. THAT NURSING EDUCATION RECEIVE -AS DO
6 OTHER COMPARABLE EDUCATIONAL PROGRAMS -
7 BOTH PUBLIC AND PRIVATE FINANCIAL
8 SUPPORT. THE CANADIAN NURSES' ASSOCIATION
9 RECOGNIZES THAT AT PRESENT, PUBLIC MONIES
10 ARE AVAILABLE TO HOSPITAL SCHOOLS OF
11 NURSING THROUGH HOSPITAL INSURANCE
12 SYSTEMS AND WOULD ADVOCATE THAT WHEN
13 ASSIGNING SUCH MONIES, DUE CONSIDERATION
14 BE GIVEN NOT ONLY TO THE NUMBER OF STUDENTS
15 ENTROLLED, BUT ALSO TO THE NEEDS OF THE
16 SCHOOL IN RESPECT TO MAINTAINING AND
17 IMPROVING THE QUALITY OF ITS EDUCATIONAL
18 PROGRAMS

19 We agree that public funds are now
20 available to nursing education, and we
21 agree with the words of caution con-
22 cerning its good use as expressed in the
23 above policy. But no one seems to know
24 how much money is presently being expended.
25 We believe that to know is in the public
26 interest. To this end, we recommend:

- 27 a) that cost of the present system of
28 nursing education be ascertained at
29 the instigation of The Royal Com-
30 mission on Health Services.

 Further, we ask the Royal Commission
 on Health Services to:

- b) ascertain what the costs of the
 nursing education programs herein
 envisaged would be to the State;
 c) ascertain what proportion of the



not eligible for professional training
ing grants in the Province of New
(Bismarck)

7. THAT NURSING EDUCATION RECEIVES - AS TO
OTHER COMPAREABLE EDUCATIONAL PROGRAMS -
SUPPORT. THE CANADIAN NURSES' ASSOCIATION
RECOGNIZES THAT AT PRESENT, PUBLIC MONIES
ARE AVAILABLE TO HOSPITAL SCHOOLS OF
NURSING THROUGH HOSPITAL INSURANCE
SYSTEMS AND WOULD ADVOCATE THAT WHEN
BE GIVEN NOT ONLY TO THE NUMBER OF STUDENTS
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- a) that cost of the present system of
nursing education be ascertained at
the instigation of the Royal Com-
mission on Health Services.
- b) ascertain what the costs of the
nursing education programs herein
envisaged would be to the State;
- c) ascertain what proportion of the



total educational expenditure of the
State ~~should~~ be allocated to nursing.

8. THAT THE ASSOCIATION CONTINUOUSLY REVIEW
THE EDUCATIONAL PROGRAMS FOR NURSING
PERSONNEL BOTH AT THE BASIC AND AD-
VANCED LEVELS, IN THE LIGHT OF NEW DE-
VELOPMENTS

Other than to concur, we have no
comments on the above policy.

total educational expenditure of 2000
state should be allocated to nursing

8. THAT THE ASSOCIATION CONTINUOUSLY REVIEW
THE EDUCATIONAL PROGRAM FOR NURSING
PERSONNEL BOTH AT THE BASIC AND AD-
VANCED LEVELS, IN THE LIGHT OF NEW DE-

Other than to correct, we have no

comment on the above policy.



PART V.

ON NURSING SERVICES

1. The New Brunswick Association of Registered Nurses accepts the concept that health is physical, mental, and social well-being; from this we presume that the provision of health services will be concerned with physical, mental, and social needs; such services require workers who possess the sum of knowledge about the human body, the human personality, and the physical and personal environment; the sum of this knowledge is so great (and must become greater) that the total contribution to the individual must be made by a diverse number of people who represent different disciplines. Not all these people function from within a given health service; all are able to make the contribution which equates to their body of knowledge; and the result within our health services is an intricate and disciplined division of labour.

2. The two most prominent workers (i.e., by tradition and by numbers) are the doctors and the nurses. Each one brings a unique contribution to the patient; but without any destruction to or contradiction in the uniqueness of each role, there is often a blurring in their division of labour. Broadly speaking, the doctor performs those activities contributing to positive health which the individual could not perform for himself because he does not have the knowledge; the nurse performs those activities which the individual could perform for himself, had he the knowledge, the

The New International Association of Registered

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ing in their division of labour. Broadly speaking,

the doctor performs those activities contributing to

positive health which the individual could not perform

for himself because he does not have the knowledge; the

nurse performs those activities which the individual

could perform for himself, had he the knowledge, the



1 will, or the strength.

2 The blurring in the doctor-nurse roles is in
3 the technique area. When the use of a medical
4 technique becomes commonplace, nursing tends to take
5 over that particular technique. Frequency of use
6 seems to be the rule of thumb in differentiating the
7 medical-technical role in the doctor-nurse relationship.
8 So far, this taking over of medical techniques seems
9 to have been accidental rather than conscious. Perhaps
10 the disciplines of medicine and nursing are sophisticated
11 enough now to make conscious agreement on the division
12 of role with reference to techniques. And perhaps
13 better patient care would be the result.

14 3. When it comes to performing those tasks for
15 the individual which he would do for himself were he to
16 have the knowledge, the will, or the strength, nursing's
17 role is unique. Obviously the circumstances decree
18 the amount of knowledge and skill required. To look
19 after a diabetic patient when he is ready for dis-
20 charge.

21 4. There can be no quarrel with the fact that
22 nursing, both quantitatively and qualitatively, pierces
23 and holds together the sum of the hospital fabric. In
24 terms of quantity, one hears much of the nursing
25 shortage - and this in spite of the fact that we pro-
26 bably have the ratio of nurses to population which we
27 can expect (Appendices VI.-A and VI.-B), considering
28 all the factors which are involved in the spread of any
29 labour force in our culture. It is with the utilization
30 of nursing power that our Association is most urgently



The planning in the doctor-nurse roles is in the technique area. When the use of a medical technique becomes commonplace, nursing tends to take over that particular technique. Frequency of use seems to be the rule of thumb in differentiating the medical-technical role in the doctor-nurse relationship. So far, this taking over of medical techniques seems to have been accidental rather than conscious. Perhaps the disciplines of medicine and nursing are specialized enough now to make conscious agreement on the division of role with reference to techniques. And perhaps better patient care would be the result.

3. When it comes to performing those tasks for the individual which he would do for himself were he to have the knowledge, the will, or the strength, nursing's role is unique. Obviously the circumstances dictate the amount of knowledge and skill required. To look after a diabetic patient when he is ready for dis-

4. There can be no quarrel with the fact that nursing, both quantitatively and qualitatively, plays and holds together the sum of the hospital fabric. In terms of quantity, one hears much of the nursing shortage - and this in spite of the fact that we probably have the ratio of nurses to population which we can expect (Appendices VI-A and VI-B). Considering all the factors which are involved in the spread of any latent force in our culture, it is with the utilization of nursing power that our Association is most urgently



1 concerned - not with the numbers of young women who
2 choose to be nurses. For this reason, our re-
3 commendation concerning the utilization of the
4 services of nurses is important.

5 5. To deal in the utilization of nursing
6 services in terms of quantity without also looking at
7 quality of service is to beg the question of patient
8 care. Two factors are involved here:

- 9 1. the measure of quality of service as
10 rendered by nursing and as needed by
11 the patient; and
- 12 2. the measure of efficiency with which the
13 nursing system can function in the
14 hospital environment.

15 Society can, with conscious choice, decide to measure
16 and hold the conditions of a simpler age or to foster
17 and expedite those forces which are even now giving
18 us the direction in which to go. If it is to be the
19 latter, two principles must be accepted:

- 20 1. traditional powers must accept pro-
21 fessional nursing's own judgment of the
22 quality of service needed; and
- 23 2. traditional authority figures must shift
24 and veer away from direct control of the
25 administration of the nursing service in
26 the hospital.

27 If it is to be the former, two facts must be accepted:

- 28 1. Intelligence, and a professional ed-
29 ucation which equates to the value which
30 we now place on intelligence, are not
needed in nursing. It would therefore
become wasteful of our human resources to
invite intelligent people into nursing.
2. Self-government and self-direction cannot
be left to the nursing group. It would
therefore become necessary that the
total management of nursing be assumed
by some other group.

6. The heart of the matter is whether the people

THE NURSING PROFESSION

...ulation concerning the utilization of the

services of nurses is important.

5. To deal in the utilization of nursing

services in terms of quantity without also looking at

quality of service is to beg the question of patient

1. the measure of quality of service as rendered by nursing and as needed by the patient; and

2. the measure of efficiency with which the nursing system can function in the hospital environment.

Society can, with conscious choice, decide to measure

and hold the conditions of a simpler age or to foster

and expedite those forces which are even now driving

us the direction in which to go. It is to be the

latter, two principles must be accepted:

1. professional powers must accept the professional nursing's own judgment of the quality of service needed; and

2. traditional authority figures must shift and very far from direct control of the administration of the nursing service in the hospital.

If it is to be the former, two facts must be accepted:

1. Intelligence, and a professional education which equates to the value which we now place on intelligence, are not needed in nursing. It would therefore become wasteful of our human resources to invite intelligent people into nursing.

2. Self-government and self-direction cannot be left to the nursing group. It would be a disaster. Total management of nursing be assumed by some other group.



1 of Canada want a nursing service which reflects pro-
2 fessionalism. It is as impossible to build a modern
3 nursing service on our pre-war (1939 1945) concept
4 of health services as it is to build a skyscraper on
5 the foundations of a five-room bungalow. What per-
6 centage in the over-all operational cost of the
7 hospital system in our province is a nursing cost?
8 On the answer to this question hangs the magnitude of
9 nursing in the hospital system.

10 7. Nursing needs to know for sure whether its
11 concept of quality in patient care corresponds to the
12 purpose of the hospital or other health agency. If
13 we are using meaningless phrases with respect to what
14 is necessary in the provision of nursing service, we
15 need an environment which can permit fulfilment of this
16 aim. At the moment we believe that the provision of
17 necessary nursing service is the implementation,
18 management, and supervision of the nursing care of the
19 patient, including:

- 20 a) individualized care based on the nursing
21 assessment of individual needs;
- 22 b) interpretative observation of and judicious
23 action relating to the physical, mental
24 and social condition of the patient;
- 25 c) accurate reporting, recording, and
26 evaluation of observations, as the
27 springboard to appropriate action;
- 28 d) knowledge (of principles) which results
29 in the application of nursing procedures
30 and techniques;



...of health services as it is to build a system on the foundations of a five-room building. What new...

centage in the over-all operational cost of the hospital system in our province is a nursing cost?

On the answer to this question hangs the magnitude of nursing in the hospital system.

7. Nursing needs to know for sure whether its concept of quality in patient care corresponds to the purpose of the hospital or other health agency. If

we are using meaningless phrases with respect to what is necessary in the provision of nursing service, we

need an environment which can permit fulfillment of this aim. At the moment we believe that the provision of

necessary nursing service is the implementation, management, and supervision of the nursing care of the

patient, including:

a) individualized care based on the nursing assessment of individual needs;

b) interpretative observation of and judgment on action relating to the physical, mental

and social condition of the patient;

accurate reporting, recording, and evaluation of observations, as the appropriate action;

knowledge (of principles) which results in the application of nursing procedures

- e) administration of the legal prescriptions and medications of physicians, with an understanding of cause and effect thereof;
- f) determination of the concentration of nursing requirements (i.e., staffing) for the patient, presupposing that sound administrative policies exist;
- g) supervision of nursing (and of the auxiliary personnel which has been placed under nursing);
- h) cooperation, and when necessary the initiation of co-operation, with other members of the health team.

8. Furthermore, it is within the nature of our work that we not only nurse the sick, but administer, through a hierarchy of organization, our own service.

If efficiency can be achieved through skilled administration, if efficiency pertains to both human and physical facilities, and if efficiency has both economic and humanistic values, we recommend that:

an action research project in the administration of the nursing service of the hospital be undertaken in this province (or in some other province if more suitable to the purpose) in order to establish the factors, both measurable and intangible, which result in efficient administration.

9. Using the word "institution" in its sociological sense, nursing services should be available to the following institutions:

e) administration of the legal prescription

and medication of physicians, with an

understanding of cause and effect thereof;

observation of the cooperation of

sound administrative policies exist;

g) supervision of nursing (and of the

auxiliary personnel which has been

placed under nursing);

h) cooperation, and when necessary the

initiation of co-operation, with other

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of the nursing service of the hospital

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other province if more suitable to the

purpose), in order to ascertain the factors,

both measurable and intangible, which result

in efficient administration.

9. Using the word "institution" in its generic

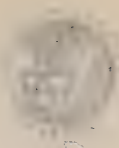
sense, nursing services should be available to the

following institutions:

1 hospitals for the acutely ill;
2 outpatient institutions;
3 institutions for convalescent care and re-
4 habilitation;
5 institutions for long term illness;
6 home care;
7 public health services

8 (see Appendices V.-A, VI.-A, and VI.-B).

- 9 a) Hospitals for the acutely ill are work-
10 shops for the repair of human beings.
11 Such a concept makes it imperative that
12 health service needs be spread over other
13 types and forms of institutions.
- 14 b) Outpatient institutions, either as depart-
15 ments of hospitals or as separate in-
16 stitutions, are needed for diagnostic
17 services and for the treatment of ills
18 which do not require intensive care.
- 19 c) Institutions for convalescent care and
20 rehabilitation, either as departments
21 of hospitals or as separate institutions
22 are obviously needed.
- 23 d) Institutions for long term illness, in
24 cluding geriatrics, are needed for those
25 people for whom a home care plan is con-
26 traindicated.
- 27 e) Home care, correlated with all the health
28 and welfare services of the community,
29 is urgently needed (including nursing
30 homes as well as private homes).



...
...
...
...
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habitation;

...
...

home care;

public health services

(see Appendices V-A, VI-A, and VI-B).

a) Hospitals for the severely ill are work-

shops for the repair of human beings.

Such a concept makes it imperative that

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stitutions, are needed for diagnostic

services and for the treatment of ill

which do not require intensive care.

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rehabilitation, either as departments

of hospitals or as separate institutions

are obviously needed.

d) Institutions for long term illness in

people for whom a home care plan is con-

sidered.

and welfare services of the community.

homes as well as private homes).



f) Public health services, with the traditional accent on prevention, need to be extended, in terms of intensity, quality, and quantity.

10. Facilities:

a) Human:

1) The Director of Nursing is the administrative head of the nursing service. To hold this position, she should:

- be a professional nurse (see page 15);
- have a graduate degree in administration;
- have several years of varied experience in nursing service, through positions of increasing responsibility;
- be granted the status (in fact and in salary) equivalent to the vice-president of any industry of corresponding size in our culture;
- communicate to the administrator, and when the administrator is not a nurse, direct to the board of management on matters pertaining to nursing; and to her assistants and head nurses;
- be eligible to advance (all other things being equal) to the chief executive office of the hospital (i.e., president, or executive director or administrator).

2) Administrative assistants and/or supervisors to the Director of Nursing should be available to the number and quality needed to implement efficiently the nursing service in a particular hospital.

Administrative assistants and supervisors



...on prevention, need
to be extended, in terms of hospital
quality, and quantity.

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ministrative head of the nursing service.

To hold this position, one should:

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- tion;

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and when the administrator is not a
nurse, direct to the board of manage-
ment on matters pertaining to nursing
and to her satisfaction and head
nurses;

- be eligible to advance (all other
things being equal) to the chief
executive officer of the hospital
(i.e., president, or executive
director or administrator).

Supervisors to the Director of Nursing

should be available to the number and

quality needed to implement effectively

the nursing service in a particular

Administrative assistants and supervisors



1 should:

- 2 - be professional nurses;
- 3 - have a graduate degree in administra-
- 4 tion or an appropriate nursing
- 5 specialty;
- 6 - have several years of experience in
- 7 nursing service reflecting administra-
- 8 tive roles or clinical specialty roles;
- 9 - have status and authority commensurate
- 10 with the responsibility which has been
- 11 delegated by the director of nursing;
- 12 - communicate to the director of nursing
- 13 and to head nurses.

14 3) Head nurses should:

- 15 - be professional nurses;
- 16 - have graduate degrees in administration;
- 17 - have one to two years' experience at
- 18 staff nurse level;
- 19 - have authority commensurate with the
- 20 responsibility which has been delegated
- 21 by the director of nursing for her unit
- 22 area, including all unit workers
- 23 assigned to her area;
- 24 - communicate directly to the team
- 25 leaders and to administrative assistants
- 26 in functional matters;
- 27 - communicate directly to the director
- 28 of nursing under extraordinary cir-
- 29 cumstances.

30 4) Team leaders should:

- be professional nurses (their basic
- nursing education should qualify
- them for this role).

5) Staff nurses should:

- be professional nurses;
- be technical nurses;
- in a ratio of one professional nurse
- to four technical nurses.

6) Nurse-specialists should:



- have a graduate degree in administration or an appropriate nursing

- have several years of experience in

give roles or clinical, specialty roles;

- have status and authority commensurate with the responsibility which has been delegated by the director of nursing;

- communicate to the director of nursing and to head nurses;

- be professional nurses;

- have graduate degrees in administration;

- have one to two years' experience at staff nurse level;

- have authority commensurate with the responsibility which has been delegated by the director of nursing for her unit area, including all staff workers assigned to her area;

- communicate directly to the team leaders and to administrative assistants in functional matters;

- communicate directly to the director

commitment,

+) Team leaders should:

- be professional nurses (their basic nursing education should qualify them for this role).

- be professional nurses;

- be technical nurses;

in a ratio of one professional nurse to four technical nurses.

6) Nurse-specialists should:



- be professional nurses;
- be qualified in graduate schools in the clinical specialties (i.e., medical-surgical, paediatric, obstetric, and psychiatric nursing);
- may be fully employed as consultants or as practitioners;
- may seek free-lance employment.

b) Physical:

The physical plant, be it the office of a public health nursing agency or a hospital for the acutely ill, should be designed and equipped for its task. Anything which automation has to offer by way of reducing human effort should be used. Since nursing service is an essential part of any health service, nursing should contribute to the plan and organization of any institution.

c) Human (other than nursing):

No matter how efficient nursing service might some day become, the quality of its administration will be affected by the quality of overall administration. It is imperative, then, that an impeccable standard of administrative performance at all levels be expected. To this end, one can surely expect that key executive officers will have formal as well as personal qualifications in administration.

We are concerned too about the role of the



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1 hospital board in its relatedness to the
2 administration of the hospital insurance
3 system. As we see it, hospital boards
4 are the last lines of defense in quality
5 of patient care. Can we look to these
6 hospital boards to check and to balance
7 the power intrinsic in the hospital
8 insurance system?

9 11. We believe that the public interest can be
10 served through the establishment of a provincial
11 Advisory Committee to the Department of Health on
12 Health Services. We recommend:

- 13 1. that the New Brunswick Association of
14 Registered Nurses be represented on an
15 Advisory Committee to the Department of
16 Health on Health Services.
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PART VI

ECONOMIC SECURITY OF NURSES

1. Nursing, to its credit or its shame, has never seized the opportunity to manipulate the rule of supply and demand to its economic advantage. Anyway, we subscribe to the belief that all health services should be removed from the free play of the price mechanism. We believe that the value which society places on a given role should be reflected in the salary paid for that role. At this moment the value placed on nursing, in the economic sense, does not seem to be excessive. Is the mantle of charity from a less sophisticated age clouding the public image, as well as our own, of the modern nurse?

2. Judging by the incomes of other professional people in the health field, it would seem that there are ways of equating income to responsibility, service, preparation and status. It seems fair to expect that nursing salaries should be equated in similar fashion. To this end, we recommend

1. that nursing salaries be equated to the responsibility, service, preparation and status of the individual nurse.

3. We note that all professions, through their organizations, possess a considerable degree of control over their working conditions and their remuneration. The same is true of job security and tenure. All too frequently nursing is dismayed at the ease with which key nursing personnel can be dis-

1. Nursing, to its credit or its shame, has never seized the opportunity to manipulate the role of supply and demand to its economic advantage. Any way, we subscribe to the belief that all health services should be removed from the free play of the market mechanism. We believe that the value which society places on a given role should be reflected in the salary paid for that role. At this moment the value placed on nursing, in the economic sense, does not seem to be excessive. In the matter of charity from a less sophisticated age clouding the public mind, as well as our own, of the modern nurse?

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3. Organizations, possess a considerable degree of control over their working conditions and their remuneration. The same is true of the security and tenure. All too frequently nursing is classed at the same with which any nursing personnel can be dis-



1 missed - often at the decision of authorities with
2 little or no professional training, and therefore
3 little or no skill in evaluating worth. All too
4 frequently we are dismayed with employer and public
5 reaction over our small gains in remuneration and
6 working conditions. Surely it should come as no
7 surprise to the public and to our fellow-workers that
8 we should seek out and exert reasonable
9 control over our remuneration, conditions
10 of work, job security and tenure.

11 4. On the question of superannuation, we
12 recommend

- 13 1. that pension systems (the cost of which
14 to be borne by employer and employee)
15 be made available to all nurses. (We
16 urge support of the plan of the Canadian
17 Nurses' Association.)
- 18 2. that all pension systems in Canada be
19 made portable.

20 5. Over the years, a strange situation has
21 developed in our hospitals and health agencies with
22 respect to our practitioners of nursing care, namely:
23 there seems to be no willingness to make their salaries
24 commensurate with the value of their contribution. The
25 only way to advance in salary (and unfortunately,
26 sometimes in prestige) is to cease to be a practitioner
27 and become an administrator. Yet the most precious
28 commodity which the public needs from nurses in
29 nursing care. We submit that many of our best nurses
30 would prefer to remain practitioners of nursing care



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1 were salaries and prestige symbols made relative. In
2 order to keep a fair proportion of our most able
3 nurses in their original practitioner roles we
4 recommend

- 5 1. that there be no ceiling on the
6 salary which a practitioner of
7 nursing care can achieve.

8 6. Nearly 50% of the nurses in our province
9 presently engaged in our nursing services are married
10 women. Were all of them to cease to work at the
11 same time the bottom would fall out of our nursing
12 services. Yet married nurses in our province are quite
13 legally discriminated against in our government ser-
14 vices in terms of salary, tenure, superannuation and
15 holiday time. To remove this archaic state of
16 affairs, we recommend

- 17 1. that there be no discrimination
18 against married women who work.



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PART VII

ON CONTINUING EDUCATION

1. A formal Continuing Education Programme for nurses, as recommended in the Russell Report of 1956, was started in 1957 under the direction and sponsorship of the New Brunswick Association of Registered Nurses. In 1959 the direction and conduct of the programme became the responsibility of the newly opened School of Nursing at the University of New Brunswick. Financial assistance to the University of New Brunswick's School of Nursing from the W.K. Kellogg Foundation, Battle Creek, Michigan included support for a four year period to this Continuing Education Programme. Its purpose is implicit in its name..

2. In essence the Continuing Education Programme is a form of adult education, designed to provide the opportunity for nurses to explore and to study a variety of topics, with the expectation that better nursing service will result. Methods used have been institutes, conferences, workshops, refresher courses and summer school sessions (Appendix VII C).

3. An Advisory Committee (Appendix X), representative of all facets of nursing, works with the faculty of the School of Nursing at the University of New Brunswick. Its purpose is to assist in evaluating what has been accomplished and in formulating plans for the future. The various courses are planned primarily for the nurses of New Brunswick. (See Appendices VII, VII C



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Its purpose is to assist in evaluating what has been

accomplished and in formulating plans for the future.

The various courses are planned primarily for the

nurses of New Brunswick. (See Appendices VII, VII C



1 and B). Invitations are extended to nurses in the
2 Atlantic provinces and in Quebec and in Maine when
3 the topic to be presented is one which is of interest
4 on a wide basis. Sometimes the faculty of the
5 University of New Brunswick's School of Nursing conduct
6 the courses. Other times consultants are imported
7 from various centres in Canada and the United States.

8 4. It is our opinion that the Continuing
9 Education Programme of the University of New Brunswick's
10 School of Nursing has made a tremendous impact on
11 nurses and nursing in this region. We believe the
12 programme should continue beyond June 30, 1962, which
13 is the point at which Kellogg Foundation support
14 ceases. We recommend

- 15 1. that the University of New
16 Brunswick make permanent the
17 Continuing Education Programme.

18 5. Health agencies themselves have a responsi-
19 bility for what is generally referred to as in-service
20 education. In-service education refers to an
21 organized programme from within the agency. Its pur-
22 pose is to keep its personnel abreast of developments
23 within its own institution, and to insure that its
24 personnel are up-to-date on all scientific and social
25 advances in knowledge which pertain to the purpose of
26 the institution.

27 We recommend

28 1. that all health service intitutions pro-
29 vide an organized in-service education programme, for
30 which budget provision is made, including the designation
of a qualified staff member whose sold responsibility is
to the programme.



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within its own institution, and to insure that its

personnel are up-to-date on all scientific and social

advances in knowledge which pertain to the purpose of

the institution.

We recommend

1. that all health service institutions provide

side an organized in-service education programme. For

on budget provision is made, including the designation of qualified staff member whose sole responsibility is

Appendix I.

ENROLMENT IN HOSPITAL SCHOOLS OF NURSING IN NEW BRUNSWICK

AS OF SEPTEMBER 30, 1961

<u>School of Nursing</u>	<u>Bed Capacity</u>	<u>Enrolment in</u>			<u>Total</u>	<u>Key *</u>	<u>Key **</u>
		<u>1959</u>	<u>1960</u>	<u>1961</u>			
A	125	12	6	15	33		(3)
B	200	14	5	22	41		(3)
C	127	15	8	9	32		(3)
D	228	12	27	13	52		(2)
E	229	25	26	31	82	(1)	(2)
F	197	30	17	19	66	(1)	(2)
G	225	38	36	59	133	(1)	(2)
H	80	10	1	6	17		(3)
I	557	59	52	76	187	(1)	(2)
J	205	32	14	51	97	(1)	(2)
K	102	9	7	--	16		(3)
L	99	7	10	6	23		(3)
M	77	7	8	7	22		(3)
Total 13		270	217	315	802		

* Admissions in 1961: Key (1) - Five schools have 75% of admissions.

** Enrolment September 30, 1961:

Key (2) - Six schools have 78% of total enrolment.

Key (3) - Seven schools have 22% of total enrolment.



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EMPLOYMENT IN HOSPITAL SCHOOLS OF NURSING IN NEW HAMPSHIRE

TABLE 1

School of Nursing		Enrollment in Hospital School of Nursing		Enrollment in Hospital School of Nursing		Enrollment in Hospital School of Nursing	
A							
B		200	14	5	25	42	(3)
C		125	15	8	5	35	(3)
D		228	15	24	13	25	(2)
E		222	25	35	31	82	(1) (2)
F		124	30	14	19	64	(1) (2)
G		225	36	35	20	142	(1) (2)
H		80	10	1	5	14	(2)
I		222	25	25	25	124	(1) (2)
J		205	25	15	21	94	(1) (2)
K							
L							
M							
Total		13					

* Admissions in 1941: Key (1) - Five schools have 75% of students.

Key (2) - Six schools have 75% of total enrollment.
Key (3) - Seven schools have 50% of total enrollment.



APPENDIX I A

RATIO OF HOSPITAL SCHOOLS OF NURSING TO POPULATION*
IN THE PROVINCES OF CANADA FOR THE YEAR 1961

Province	**Population	Hospital Schools of Nursing	Ratio of Schools to Population	Other Schools giving basic course in nursing (not included in ratio)	
				University Degree course	Other
Nova Scotia	730	14	1-52	2	
Prince Edward Island	105	3	1-35		
New Brunswick	608	13	1-47	1	
Newfoundland	468	3	1-156		
Quebec	5,192	42	1-124	1	
Ontario	6,179	58	1-107	4	1
Manitoba	909	7	1-130		
Saskatchewan	914	11	1-81	1	
Alberta	1,313	12	1-109	1	
British Columbia	1,631	6	1-272	1	

*Population expressed in the thousands

**Dominion Bureau of Statistics census projection to March 31, 1961



ANNEX I

THE HOUSE OF COMMONS

Other persons in the		Part of		House		of		The	
House		House		House		House		House	



Appendix II.

* A BREAKDOWN OF THE GENERAL AVERAGES OF ENTRANTS TO
SCHOOLS OF NURSING IN NEW BRUNSWICK, SEPT. 1961

School of Nursing	50% 59%	60% 69%	70% and over	** Not available
A	6	17	7	1
B	1	1		11
C	2	11	8	1
D	4	8	2	1
E	2	2	1	
F	5	4		
G		6		
H	20	29	9	1
I	4	13	2	
J	16	21	13	1
K	12	42	17	5
L	No class accepted			
M	5	1	1	
N		2	14	
Total	77	157	74	21
% of Total	25%	51%	24%	

* Based on an average of eight subjects only - provincial departmental examinations.

** Students from outside New Brunswick whose academic standings are equivalent to, but cannot be rated on the same basis as the academic programme in New Brunswick.



Table 1. Results of the 1971-72 Survey
of the 1000 Most Common Insects in the United States

Insect	Number of Insects			Percentage of Total
	1971	1972	1973	
1. Housefly	100	100	100	10.0
2. Mosquito	80	80	80	8.0
3. Flea	60	60	60	6.0
4. Tick	50	50	50	5.0
5. Spider	40	40	40	4.0
6. Centipede	30	30	30	3.0
7. Scorpion	20	20	20	2.0
8. Crab Spider	10	10	10	1.0
9. Wolf Spider	10	10	10	1.0
10. Brown Recluse	10	10	10	1.0
11. Black Widow	10	10	10	1.0
12. Yellow Jacket	10	10	10	1.0
13. Paper Wasp	10	10	10	1.0
14. Honey Bee	10	10	10	1.0
15. Fire Ant	10	10	10	1.0
16. Termite	10	10	10	1.0
17. Carpenter Ant	10	10	10	1.0
18. Cockroach	10	10	10	1.0
19. Silverfish	10	10	10	1.0
20. Bluegill	10	10	10	1.0

* Based on an average of eight months of data - November through April.
** Students from outside the University of California at Berkeley are not included in the survey as the number of students from outside the University is too small to be significant.



Appendix III.

THE NEW BRUNSWICK ASSOCIATION OF REGISTERED
NURSES

ACADEMIC QUALIFICATIONS FOR ENTRANCE TO A
SCHOOL OF NURSING IN NEW BRUNSWICK

English I
English II
History
One Science (Chemistry, Physics, or Biology)
Two Mathematics (Algebra, Geometry, Arithmetic)

Algebra or Geometry must be chosen
as one subject in Mathematics.

Two other optional subjects not previously selected as
compulsory subjects, or French I, French II, French
III, Latin, English III, General Mathematics, Senior
Mathematics.

O R

French I
French II
History
English III
One Science (Chemistry, Physics, or Biology)

Two Mathematics (Algebra, Geometry, Arithmetic)

Algebra or Geometry must be chosen
as one subject in Mathematics.

One other optional subject not previously selected or
English I, English II, French III, Latin, General
Mathematics, Senior Mathematics.

Home Economics Course

English I	French I
English II	French II
French III	English III
History	History
Chemistry or Physics	Chemistry or Physics
Senior Mathematics or	Senior Mathematics or
Biology	Biology
General Mathematics	General Mathematics
Home Economics	Home Economics

N.B. - A minimum of eight subjects is required with com-
pulsory and optional as noted above and with a grade of
50% on each subject.

September 1961

SCHOOL OF INSTRUCTION IN NEW BRUNSWICK

English I
English II
History
One Science (Chemistry, Physics, or Biology)
Two Mathematics (Algebra, Geometry, Arithmetic)

Algebra or Geometry must be chosen
as one subject in Mathematics.

Two other optional subjects not previously selected as
compulsory subjects, or French I, French II, French
III, Latin, English III, General Mathematics, Senior
Mathematics.

0 8

French I
French II
English III
Two Mathematics (Algebra, Geometry, Arithmetic)

Algebra or Geometry must be chosen
as one subject in Mathematics.

One other optional subject not previously selected or
English I, English II, French III, Latin, General

Home Economics Course

English I
English II
English III
Chemistry or Physics
Senior Mathematics or
General Mathematics or

Home Economics

N.B. - A minimum of eight subjects is required with com-
pulsory and optional as noted above and with a grade of
50% on each subject.



APPENDIX IV

ACTUAL DIRECT COST OF NURSING EDUCATION
IN HOSPITAL SCHOOLS, PROVINCE OF NEW BRUNSWICK
1960

Hospital School	I	\$56,998.73
"	II	52,537.52
"	III	59,030.69
"	IV	19,163.91
"	V	48,618.73
"	VI	102,739.76
"	VII	116,473.49
"	VIII	87,341.57
"	IX	18,272.90
"	X	87,841.47
"	XI	201,436.96
"	XII	29,126.98
"	XIII	39,410.64
"	XIV	25,847.72
		<hr/>
		\$944,841.07
Number of Students		750
Cost per Student		\$ 1,259.*

The above figures represent only those direct charges made to nursing education by the hospital, and do not reflect any direct charges such as light, heat, telephone, travel, etc.

* This figure is known to be inaccurate, but it does approximate to other figures. It is presented because of its relative significance.

APPENDIX IV

ANNUAL REPORT OF THE
SCHOOL OF THE PROVINCE OF NEW BRUNSWICK
1900

Hospital School		
"	"	32,334.55
"	"	
IV	"	
V	"	16,610.73
V	"	102,730.76
VII	"	112,673.41
VIII	"	87,301.27
IX	"	
	"	87,801.47
	"	201,482.90
	"	
	"	
XIV	"	12,641.72
		391,602.01

Number of Students
Cost per Student

The above figures represent only those direct charges made to nursing education by the hospital, and do not reflect any direct charges such as light, heat, telephone, travel,

* This figure is known to be inaccurate, but presented because of its relative significance.

APPENDIX IV A

* COST PER STUDENT PER NINE
HOSPITAL SCHOOLS OF NURSING
IN NEW BRUNSWICK, SEPTEMBER,
1960

<u>School of Nursing</u>	<u>Cost per Student</u>
A	- \$ 900.34
B	- 1,194.64
C	- 1,039.94
D	- 1,323.35
E	- 1,074.88
F	- 1,220.02
G	- 1,274.91
H	- 1,078.77
I	- 957.32

* Figures for hospitals which operate both
schools of nursing and schools for
nursing assistants are not included in
this table.



APPENDIX IV B

COSTS

University of New Brunswick

July 1, 1960 - June 30, 1961

Total operational cost	\$2,680,287
Total student enrollment. . . .	2085
Cost per student	1489

Metropolitan Demonstration School of Nursing 1952

Total annual cost per student	\$ 1253
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The Atkinson School of Nursing, Toronto Western
Hospital

1950-1955

Total annual cost per student	\$ 1302
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Cost Study of Basic Nursing Education Programmes

in Saskatchewan by Lola Wilson 1958

Average net cost to hospitals per

student	\$ 228
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University of New Brunswick

July 1, 1950 - June 30, 1951

Total operational cost . . . \$2,686,287

Total student enrollment . . . 2081

Metropolitan Demonstration School of Nursing 1952

Total annual cost per student \$ 1952

The Atkinson School of Nursing, Toronto Western
Hospital

1950-1952

Total annual cost per student \$ 1952

Cost Study of Basic Nursing Admission Programmes

in Saskatchewan by Lois Wilson 1958

Average net cost to hospitals per

student \$



Appendix V.

AN ANALYSIS OF THE EDUCATIONAL BACKGROUND
OF TEACHERS IN SCHOOLS OF NURSING IN NEW BRUNSWICK
SEPTEMBER 1961

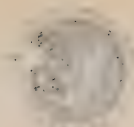
Hospital School of Nursing	Number of Instructors	Master's Degree	Bachelor's Degree	University Diploma Course	Clinical Course (less than six mos.)
1	7		1	2	
2	11		2	1	4
3	10	1		4	2
4	10		1	7	2
5	14		1	8	1
6	15		5	9	1
7	4			1	2
8	5			1	2
9	5		2	1	2
10	6		1	2	1
11	7		2	1	1
12	2			2	
13	4			1	
Total	100	1	15	40	18

U. N. B. S. of N.	7	4	3		
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N.B. Re. the first six schools of nursing:

- (1) out of 40 teachers with a University Diploma Course, there are 31 or 76% on the staff;
- (2) out of 15 teachers with a Bachelor's Degree, there are 10 or 66 2/3% on the staff;
- (3) they employ 70% of the instructors.

Thirty per cent (30%) of the instructors are spread over the remaining seven schools.





APPENDIX VA

ANALYSIS OF EDUCATIONAL BACKGROUND OF NURSES EMPLOYED
IN NEW BRUNSWICK ACCORDING TO SERVICE AREAS AS OF SEPTEMBER 1961

	Masters Degree	Bachelors Degree	Diploma	6 months or less Clinical Course	Registered Nurse	Total
Nursing Education	5	19	39	18	19	100
Nursing Service		2	20	86	1159	1267
Public Health	1	4	37		35	77
Private Duty					229	229
Others			5		33	38
TOTAL	6	25	101	104	1475	1711

1 Difficult to ascertain educational background.

2 Includes New Brunswick Association of Registered Nurses, Hospital Services Department,
St. John's Ambulance, School Nurses, etc.

Appendix VI

REGISTERED NURSES IN NEW BRUNSWICK
FOR THE YEARS 1956 TO 1961 (INCLUSIVE)

<u>Year</u>	<u>Active</u>			<u>Non-practising</u>			<u>Grand Total</u>
	<u>Married</u>	<u>Single</u>	<u>Total</u>	<u>Married</u>	<u>Single</u>	<u>Total</u>	
1956	603	1,021	1,624	558	258	816	2,440
1957	660	968	1,628	544	220	764	2,392
1958	747	1,060	1,807	728	283	1,011	2,818
1959	890	1,084	1,974	754	263	1,017	2,991
1960	1,151	1,012	2,163	718	216	934	3,097
1961 Jan. 1 to Sept. 30	1,200	1,150	2,350	619	207	826	3,276

103. 1902



APPENDIX VI A

NUMBER OF NURSES EMPLOYED IN NEW BRUNSWICK IN 1955
AND COMPARED WITH THE NUMBER EMPLOYED IN 1961

	Number 1955	Percent 1955	Number 1961	Percent 1961
1 Total Registered	1,570		2,300	
2 Total Active	1,124	100%	1,675	100%
Employed in Hospitals	320	73%	1,400	83%
4 Employed in Public Health and Other Fields	37	7%	121	8%
3 Employed in Private practice	217	20%	154	9%

1 Total Registered Nurses in the New Brunswick Association of Registered Nurses for 1955, 1961.

2 The approximate number of Registered Nurses actively engaged in Nursing, 1955, 1961.
(a) Not 100% employed are registered.
(b) Part-time Nurses drawn from "Free-lance" pool of Nurses.
(c) Difficulty in obtaining full information.
(d) Migration of New Graduates.

3 Included only those who are Members of the Registry.

4 Others include University School of Nursing, New Brunswick, Association of Registered Nurses, Hospital Service Division.



APPENDIX VI B
THE POPULATION, NUMBER OF NURSES AND THE RATIO
OF ACTIVE NURSES PER 1000 POPULATION IN THE COUNTIES AND
IN THE PROVINCE OF NEW BRUNSWICK IN 1957 AND 1960

COUNTIES	¹ Popula- tion 1957	² No. of Active Nurses 1957	No. of Nurses per 1000 Pop. 1957	¹ Popula- tion 1959	² No. of Active Nurses 1960-61	No. of Nurses per 1000 Pop. 1960
ALBERT ⁴	11,142	9	1.3	11,520	22	1.9
CARLETON	23,849	52	4.5	24,271	65	3.7
CHARLOTTE	24,809	88	2.8	25,303	74	2.9
GLOUCESTER	65,959	84	7.9	63,313	117	5.4
KENT	23,081	15	1.9	29,208	17	1.1
KINGS ³	24,626	50	4.9	25,964	67	3.5
MADAWASKA	36,081	63	6.1	39,964	66	5.1
NORTHUMBERLAND	48,508	124	3.9	50,954	157	3.3
QUEENS ^{5, 3}	13,016	19	6.8	13,350	22	6.0
RESTIGOUCHE	40,851	80	5.1	42,968	133	3.2
SUNBURY ⁵	10,816	15	7.2	11,795	12	9.8
SAINT JOHN ³	82,838	441	1.9	85,579	521	1.1
VICTORIA	19,579	27	7.5	20,539	29	1.1
WESTMORLAND ⁴	87,272	240	3.6	90,828	349	2.6
YORK ⁵	48,023	167	2.8	49,880	262	1.1
TOTAL	567,041	1513	3.75	590,666	1923	2.9

¹ County population according to Annual Report Chief Medical Officer,
Minister of Health and Social Service 1958, 1960.

² Active membership New Brunswick Association of Registered Nurses approximately.

³ Many nurses in Kings, Queens and Saint John Counties service Saint John County
and Saint John City Hospitals and Health Services.

⁴ Many nurses in Albert and Westmorland Counties service Hospital and Health
Agencies in Moncton.

⁵ Many nurses in York, Sunbury and Queens Counties service Fredericton Hospitals
and Health Agencies.



Appendix VI. -C

A SUMMARY OF THE CONTINUING EDUCATION PROGRAMME
SHOWING GROUPS AND TOPICS

June 1959 - August 1960

	<u>Group</u>	<u>Topic</u>
Institute	Instructors in Schools of Nursing	Curriculum Planning and Teaching of Nurs- ing
Refresher Courses	All graduate nurses in five centres in the province - 3 hour sessions re- peated twice daily for 5 days.	Physiological Aspects of Nursing
Institute	Directors of Nursing	Master Rotation Plan- ning and Budget Plan- ning for Schools of Nursing
Institute	Hospital and Public Health Nurses	Planning for Con- tinuity of Care during the Maternity Cycle
Institute	Directors of Nursing	Planning for Schools of Nursing for the Future
Institute	Instructors in Schools of Nursing	Sciences in the Basic Curriculum
Summer Session	Open	Ward Administration

September 1960 - August 1961

Institute	Hospitals and Public Health Nurses	The Psychological and Sociological Aspects in Illness and in Patient Care
Institute	Senior Public Health Nurses in New Brunswick	Administration in Public Health Nursing

A SUMMARY OF THE CONTINUING EDUCATION PROGRAMME
SHOWING GROUPS AND TOPICS

Topic	Group	
Curriculum Planning and Teaching of Nursing	Institute	8
Physiological aspects of Nursing	All Graduate Nurses in five centres in the province - 3 hour sessions repeated twice daily for 5 days.	10
Master Rotation Planning and Budget Planning for Schools of Nursing	Directors of Nursing	13
Planning for the Maternity Cycle	Hospital and Public	15
Planning for Schools of Nursing for the	Directors of Nursing	18
Sciences in the Basic Curriculum	Institute	20
September 1960 - August 1961		22
The Psychological and in Illness and in	Hospitals and	25
Public Health Nursing Administration in	General Public Health Nursing	27



Appendix VI. -C - (continued)

Institute	Directors of Nursing and Assoc- iate Directors of Nursing Education	Evaluative Techniques in Schools of Nursing
Refresher Courses	All graduate nurses in 8 centres in the province 8 hours sessions repeated twice daily for 5 days	Physiological Aspects of Nursing
Summer Session	Hospital nurses	1 - Ward Administration 2 - Clinical Nursing (Medical and Surgical Nursing)

September 1961 - August 1962

Institute	Hospital and Public Health Nurses	Prenatal Teaching
Institute	Any graduate nurse	Geriatric nursing (will be given twice)
Institute	Senior Public Health Nurses in New Brunswick	Administration
Institute	Directors of Nursing and Associate Directors of Nursing Service	Nursing Service Area
Summer Session	Number and areas to be determined	

Appendix VI. - C - (cont.)

General Nursing	Nurses	In 8 centres in the province 8 hours sessions repeated twice daily for 5 days
Hospital nurses	1 - Ward Administrative (Medical and Surgical Nursing)	Summer

September 1941 - August 1942

Institute	Hospital and Public Health Nurses	Prenatal Teaching
Institute	Senior Public Health Nurses in New Brunswick	Administration (will be given twice)
Institute	Nurses in New Brunswick	of Nursing Service
Summer	Number and areas to be	



APPENDIX VII

THE NUMBER OF NURSES ATTENDING
INSTITUTES, CONFERENCES, WORKSHOPS AND
SUMMER SCHOOL OCTOBER 1957-1961

	1957 ¹	1958 ¹	1959 ²	1960	1961	TOTAL
Institutional Nurses	40	101	375	875	113	1501 ³
Nurses from Official and Voluntary Agencies		2	15	73	30	120
Others		6	45	72	12	135
Atlantic Provinces other than New Brunswick			11	26	23	60
Nurses from outside Atlantic provinces				22	7	29
TOTAL	40	109	446	1068	185	1818

- 1 Educational Programmes sponsored by New Brunswick Association of Registered Nurses.
2 School of Nursing, University of New Brunswick started Continuing Education Programmes.
3 316 students of nursing included in total.

APPENDIX VII A

THE NUMBER OF NURSES ATTENDING INSTITUTES,
CONFERENCES, WORKSHOPS AND SUMMER SCHOOL FROM
OCTOBER 1957 TO OCTOBER 1961 ACCORDING TO COUNTIES
IN NEW BRUNSWICK

COUNTIES	1957	1958	1959	1960	1961	TOTAL
ALBERT						
CARLETON	1	3	1	53	5	63
CHARLOTTE	2	4	1	30	2	39
GLOUCESTER	4	9	5	91	6	115
KENT		1	3	1	1	6
KINGS				1	2	3
MADAWASKA	4	7	45	3	7	66
NORTHUMBERLAND	4	7	5	55	4	75
QUEENS						
RESTIGOUCHE	4	17	86	77	3	187
SAINT JOHN	10	22	163	313	13	521
SUNBURY						
VICTORIA		2		14	2	18
WESTMORLAND	7	21	118	194	13	353
YORK	4	16	8	188	97	313
NON-NEW BRUNSWICK			11	48	30	89
TOTAL	40	109	446	1068	185	1848



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Appendix VIII.-A

NUMBER AND PERCENTAGE OF PROFESSIONAL AND NON-PROFESSIONAL PERSONNEL
IN NEW BRUNSWICK HOSPITALS WITHOUT SCHOOLS OF NURSING, FOR 1958, 1959, 1960

HOSPITALS BY BED SIZE *	TOTAL PROFESSIONAL PERSONNEL *			TOTAL NON-PROFESSIONAL PERSONNEL *		
	1958 No.	1959 No.	%	1958 No.	1959 No.	%
Q - 14 Beds						
A	2	4	67%	3	2	33%
B	4	9	90%	4	1	10%
C	4	5	57%	3	3	38%
D	2	2	33%	4	4	67%
E	5	5	71%	1	2	29%
F	-	-	-	4	4	100%
L5 - 35 Beds						
A	6	6	60%	4	4	40%
B	8	12	60%	8	8	40%
C	5	5	45%	3	6	55%
D	16	12	17%	78	67	83%
E	1	7	9%	10	9	91%
F	-	2	17%	-	10	83%
G	6	8	43%	8	9	53%
H	5	5	56%	4	6	55%
I	3	3	43%	4	4	57%
J	-	5	16%	-	27	84%

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APPENDIX VII B

THE NUMBER OF NURSES IN NEW BRUNSWICK ATTENDING
INSTITUTES, CONFERENCES, WORKSHOPS AND SUMMER SCHOOL FROM
OCTOBER 1957 - OCTOBER 1961

	1957 ¹	1958 ¹	1959 ²	1960	1961	TOTAL
Institutional	40	101	375	875	113	1504 ³
Official and Voluntary Agencies		2	15	73	30	120
Others		6	45	72	12	135
TOTAL	40	109	435	1020	155	1759

1 Sponsored by New Brunswick Association of Registered Nurses.

2 Sponsored by University of New Brunswick School of Nursing Continuing Education Programme.

3 316 students of nursing included in total.



NUMBER AND PERCENTAGE OF PERSONNEL, PROFESSIONAL, NON-PROFESSIONAL, AND STUDENT NURSES,
IN NEW BRUNSWICK HOSPITALS WITH SCHOOLS OF NURSING, FOR 1958, 1959, 1960

HOSPITALS BY BED SIZE *	TOTAL PROFESSIONAL PERSONNEL *				TOTAL NON-PROFESSIONAL PERSONNEL *				STUDENT NURSES **									
	1958		1959		1958		1959		1958		1959		1960					
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%				
36 - 75 Beds																		
A	Not available.																	
76 - 130 Beds																		
A	--	--	36	47%	42	46%	--	--	19	25%	34	37%	--	--	21	28%	16	17%
B	21	45%	39	51%	63	61%	8	17%	15	20%	23	22%	18	38%	22	29%	17	17%
C	36	62%	47	63%	47	60%	9	16%	15	20%	20	25%	13	22%	13	17%	12	15%
D	Not available.																	
E	34	64%	26	55%	37	62%	4	8%	5	11%	8	13%	15	28%	16	34%	15	25%
131 - 230 Beds																		
A	--	--	43	47%	50	43%	--	--	39	42%	57	49%	--	--	10	11%	10	8%
B	--	--	47	34%	60	33%	--	--	75	54%	96	52%	--	--	18	13%	28	15%
C	94	47%	105	47%	127	49%	62	31%	72	32%	89	34%	45	22%	45	21%	44	17%
D	104	53%	119	52%	128	53%	42	21%	54	24%	54	23%	51	26%	54	24%	58	24%
E	48	19%	58	19%	73	22%	180	70%	210	70%	219	67%	30	11%	34	11%	34	11%
F	75	49%	77	43%	100	49%	41	27%	59	33%	68	35%	36	24%	43	24%	37	18%
Over 230 Beds																		
A	108	31%	144	32%	165	32%	150	44%	216	48%	261	51%	86	25%	93	20%	85	17%
Total	520	40%	741	39%	892	41%	496	38%	779	41%	929	43%	294	22%	369	20%	356	16%

* Total professional and non-professional personnel is the total of part-time hours converted into the equivalent number of full-time personnel plus the actual number of full-time personnel employed.

** Estimated percentage of service by student nurses in terms of professional personnel.

HOSPITALS BY BED SIZE *	TOTAL PROFESSIONAL PERSONNEL *				TOTAL NON-PROFESSIONAL PERSONNEL *			
	1958		1959		1958		1959	
	No.	%	No.	%	No.	%	No.	%
36 - 75 Beds								
A	16	89%	15	83%	2	11%	3	17%
B	29	66%	24	53%	15	34%	20	44%
C	--	--	--	--	--	--	--	--
D	--	--	9	30%	--	--	21	70%
E	12	71%	23	64%	5	29%	13	36%
F	12	40%	14	42%	18	60%	19	58%
76 - 130 Beds								
A	Not available.							
B	14	34%	18	41%	27	66%	26	59%
Total	150	43%	193	42%	205	58%	268	58%

* Total professional and non-professional personnel is the total of part-time hours converted into the equivalent number of full-time personnel plus the actual number of full-time personnel employed.



APPENDIX IX

PROVINCE OF NEW BRUNSWICK
REGISTERED NURSING ASSISTANTS

	1960 (April 1 - March 31)			1961 (April 1 - September 30)			
	*Waiver	Reciprocity	Total	*Waiver	Reciprocity	Examinations	Total
Married	130	4	134	27	3	10	40
Single	345	4	349	42	2	29	73
Total	475	8	483	69	5	39	113
Male			26				
Female			457				
Total			483				

* Waiver clause - By-Laws for Nursing Assistants

APPENDIX IX A
AN ANALYSIS OF THE ACADEMIC STANDING OF ENTRANTS TO
SCHOOLS FOR NURSING ASSISTANTS IN NEW BRUNSWICK IN 1960 AND 1961

1961											
School	No. Admitted	Entrance Educational Qualifications*				School	No. Admitted	Entrance Educational Qualifications*			
		Grade 9	Grade 10	Grade 11	Grade 12			Grade 9	Grade 10	Grade 11	Grade 12
1	23	30%	48%	13%	9%	1	27	7%	48%	26%	19%
2**	46	41%	41%	15%	3%	2**	45	41%	40%	11%	5%
3	14	7%	50%	21½%	21½%	3	17	-	56%	6%	38%
4**	36	17%	33%	7%	13%	4	27	16%	52%	24%	8%
5	15	53%	27%	-	20%	5	17	70½%	23½%	6%	-
6**	50	22%	18%	30%	30%	6**	43	46%	23%	12%	19%
7	-	-	-	-	-	7**	33	28%	45%	13½%	13½%
For all Schools	184	34½%	35%	11½%	16%	For all Schools	219	31%	40%	15%	11%

1960											
School	No. Admitted	Entrance Educational Qualifications*				School	No. Admitted	Entrance Educational Qualifications*			
		Grade 9	Grade 10	Grade 11	Grade 12			Grade 9	Grade 10	Grade 11	Grade 12
1	23	30%	48%	13%	9%	1	27	7%	48%	26%	19%
2**	46	41%	41%	15%	3%	2**	45	41%	40%	11%	5%
3	14	7%	50%	21½%	21½%	3	17	-	56%	6%	38%
4**	36	17%	33%	7%	13%	4	27	16%	52%	24%	8%
5	15	53%	27%	-	20%	5	17	70½%	23½%	6%	-
6**	50	22%	18%	30%	30%	6**	43	46%	23%	12%	19%
7	-	-	-	-	-	7**	33	28%	45%	13½%	13½%
For all Schools	184	34½%	35%	11½%	16%	For all Schools	219	31%	40%	15%	11%

* Legal minimal educational requirement for admission to a School for Nursing Assistants in New Brunswick is successful completion of Grade IX - see By-laws for Nursing Assistants, page 4, Article iii

** Admitted two classes during the year.

Schools 6 and 7 in 1961 - percentages based on spring classes only - educational credentials for fall classes not yet available.



Appendix X.

ADVISORY COMMITTEE ON THE
CONTINUING EDUCATION PROGRAM
OF THE UNIVERSITY OF NEW BRUNSWICK
SCHOOL OF NURSING

Sister Bujold

Miss M. Jean Anderson

Miss M. Jane Stephenson

Sister Helen Marie

Miss Lois Smith

Miss Muriel Hunter

Miss Doris Grieve

Miss Muriel Archibald

October 1961.



MISSOURI
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MISSOURI HISTORICAL SOCIETY
OF THE CITY OF ST. LOUIS

- Miss M. Joan Anderson
Miss M. Jane Stephenson
Miss Lola Smith
Miss Muriel Hunter
Miss Doris Grive
Miss Muriel Alchibelli

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Appendix XI.

THE NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES

Membership, Advisory Committee on Nursing

Mr. Arthur McF. Limerick, Q.C.	Fredericton, representing Hospital Board members of the New Brunswick Section of the Maritime Hospital Association
Miss M. Jean Anderson	Director of Nursing, representing the New Brunswick Association of Registered Nurses.
Dr. C. W. Argue	Dean of Science, University of New Brunswick, member-at-large
Dr. A.M. Clarke	Executive Director, Moncton Hospital Board, representing Hospital Administrators of the New Brunswick Section of the Maritime Hospital Association.
Mr. Clarence T. Clark	Mill Manager, Fraser Company, Limited, member-at-large.
Dr. Gerard de Grace	Assistant to the Chief Superintendent, representing the Department of Education
Rev. Clement Cormier	Rector, St. Joseph's University, member-at-large.
Dr. C. W. Kelly	Director of Health Planning Services, representing the Department of Health and Social Services.
Miss Katherine MacLaggan	Director, School of Nursing, University of New Brunswick, representing the University.
Rev. A. L. La Plante	Sacred Heart University, member-at-large.
Dr. W. Ross Wright	representing the New Brunswick Medical Association.
Miss Muriel Archibald	Executive Secretary, New Brunswick Association of Registered Nurses, Secretary of Committee.
* Mr. L. H. Moissan	Director, Hospital Services Commission of New Brunswick, member-at-large.

* Newly appointed to Committee.



Committee on the New Brunswick Section of the
Hospital Board members of the
New Brunswick Association of Registered Nurses.

Hospital Board members of the New Brunswick Association of Registered Nurses.	Mrs. M. Jean Anderson
Director of Nursing, representing the New Brunswick Association of Registered Nurses.	Dr. J. H. Clark
Dean of Science, University of New Brunswick member-at-large.	Dr. A. M. Clarke
Executive Director, Moncton Hospital Administrators of the New Brunswick Section of the	Dr. J. H. Clark
Member-at-large.	Dr. J. H. Clark
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Member-at-large.	Dr. J. H. Clark
Member-at-large.	Dr. J. H. Clark



Appendix XII.

MASTER DESIGN FOR NURSING IN NEW BRUNSWICK

Introduction:

In order to epitomize a sense of purpose and to focus a direction to emerging events in nursing in the Province of New Brunswick, a commitment to paper of an over-all design for nursing seems to have merit.

In order also to avoid the pitfalls of such a commitment, it seems wise to forewarn that that which is projected into the future will be modified, conditioned, and even changed by that future. To the extent that this is understood, there is merit in presenting a design.

In working out specific purposes, the design must:

1. approximate the public image of what its nursing needs are;
2. be way ahead of the public image in envisioning what the practice of nursing should become.

To avoid confusion, a delicate balance must be maintained between the presentation of ideas and their rate of implementation. The existence of a master design should help us to maintain this balance.

In so far as anything creative accrues to our efforts in nursing, education becomes the instrument of approach. For this reason, our "Master Design for Nursing in New Brunswick" is couched in educational terms. The approach is to break down the fabric of

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nursing into areas which are identifiable both to the public and professional minds; to express purposes through schemes of education for these areas of nursing; and to demonstrate, given the chance, that these areas to in fact make up the fabric of nursing which shall meet the nursing needs of society.

These areas are expressed as follows:

1. public education;
2. in-service education;
3. university education for students of nursing;
4. a new system for increased educational attainment in nursing;
5. auxiliary education;
 - (a) of the nursing assistant;
 - (b) of the housekeeper of the sick;
6. graduate education.

1. Public Education:

Many factors contribute to a distortion of the public image of nursing, nurses, and students of nursing. Any distortion cannot long continue without its own untoward effects, especially if one effect proves to be a hindrance to the solution of problems and another effect results in the unintelligent use of nursing power. To effect needed change requires the understanding and support that are implicit in an informed opinion. While much has been done in this respect already, an organized approach needs to be made.

Using the term "public" to refer to those who are not nurses, the following are required:

- (1) a public relations program;



- (2) short-term institutes and workshops for employers of nursing, administrators of nursing personnel, educators, doctors, hospital board members, interested citizens;
- (3) a medium of communication for the regular exchange of information, particularly among confreres in the health field.

2. In-service Education:

The improvement of nursing service must begin with the nurses who are presently in the field. To this end, an elaborate in-service education program is proposed. Details of approach to this area to are contained in the enclosed brief.

3. University Education for Students of Nursing:

Nursing education in New Brunswick at the pre-specialization level is controlled, managed, and financed by hospitals. Reference only can be made to the fact that this system of education has been the object of scrutiny and question by many people.

Because no institution other than the hospital has at this present an alternative to offer, much pressure is being directed to the provincial university to assume an active role in the field of nursing education.

The problem here is not alone a financial one, although its significance is not underestimated. Philosophy of education is, in the final analysis, the important question. It is generally agreed that existing patterns in Canada do not serve well our thinking at the present time. We want the opportunity to effect a research or experimental or

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opportunity to effect a research or experimental or



1 demonstration program in nursing education. From
2 this program we would hope to produce the nurse so
3 needed for nursing in these times.

4 An obstacle to such research lies in the lack
5 of a university effort in nursing education. A
6 university school is urgently needed.

7 A university school should offer a program
8 for professional nursing. The word "professional"
9 is used here to categorize that group of nurses
10 whose educational background and nursing practice
11 warrant a claim to learning, in the old-fashioned
12 and best meaning of the word. The hypothesis here
13 is that such learning largely secured in a university,
14 would produce in the student of nursing the ability
15 to practise in a professional manner.

16 It is hoped that the University of New
17 Brunswick will find the pattern of education which
18 produces the practitioner of nursing whose claim to
19 professionalism cannot be denied.

20 4. A New System for Increased Educational Attainment
21 in Nursing:

22 In searching out ways and means of separating
23 education from service, our thinking has evolved
24 to the extent that the need for a new form of
25 education is evident. The new form is needed in
26 order to offer a pattern of replacement for the
27 present hospital school of nursing.

28 We need only to find what the pattern should
29 be. The search for this new pattern should be
30 administered by the university. Thus the university

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1 has the task of formulating objectives, together
2 with methods of implementation, for this group of
3 students of nursing who may come to comprise our
4 largest graduate group, as well as for the pro-
5 fessional group referred to above.

6 5. Auxiliary Education:

7 (a) Of the Nursing Assistant:

8 The nursing assistant in this province
9 is one who has received training in a pre-
10 scribed manner through the Vocational Division
11 of the Department of Education, or through
12 those hospitals currently administering such
13 programs. Confusion of purpose presently
14 exists in the few efforts which are being
15 made.

16 Experimental or demonstration programs
17 of education are in order for this group.
18 There is good sense in assuming that some of
19 our hospitals are rich in facilities for
20 their training.

21 (b) Of the Housekeeper for the Sick:

22 Whatever the reason, nursing in all
23 forms seems to have departed from home service.
24 A serious gap in service has resulted. While
25 it may be unrealistic for the New Brunswick
26 Association of Registered Nurses to administer
27 indefinitely a training program for house-
28 keepers for the sick, it is realistic to
29 undertake responsibility for a pilot demon-
30 stration. Out of this pilot demonstration

of implementation, for this group of
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undertake responsibility for a pilot demon-
stration. Out of this pilot demonstration

could come answers to such questions as:

What type of service is needed?

What type of training will secure this service?

How and by whom should future training programs be administered?

How should the service be administered?

6. Graduate Education:

Graduate education is that specialized education which is pursued beyond the baccalaureate level. From among this group will come the specialists, teachers, administrators, researchers, and writers, so desperately needed for leadership and service in special areas. In implementing any and every phase of this design, highly qualified nursing personnel will be needed. It is essential to estimate with reasonable accuracy the numbers and types of such people needed in this province. While we may look outside our province for some personnel, we must encourage our own nurses to secure qualifications at the graduate level. Every avenue of financial aid should be explored on behalf of our potential specialists, and every encouragement offered to promising young nurses presently in the field.

Conclusion:

The attention of the Advisory Committee on Nursing in New Brunswick has been focused on all facets of nursing. To concentrate on any one phase, to the exclusion of another, creates its own impasse.

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What type of training will secure this

service?

How and by whom should future training

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secure qualifications at the graduate level.

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encouragement offered to promising young nurses

presently in the field.

Conclusion:

The attention of the Advisory Committee on

Nursing in New Brunswick has been focused on all facets

of nursing. To concentrate on any one phase, to

the exclusion of another, creates its own impasse.



1 This we want to avoid. Nevertheless, some one
2 phase must be selected as the starting point.

3 The decision to start with in-service ed-
4 ucation has been made by the New Brunswick
5 Association of Registered Nurses. The defense of
6 this decision is embodied in the importance of
7 the hospital service area to all other areas in
8 nursing.

9 The establishment of a university school of
10 nursing is an immediate and urgent need.

11 As soon as current events indicate, plans
12 must be formulated and implemented for the training
13 of the practical nurse and the housekeeper for the
14 sick.

15 Programs resulting in an informed public
16 and an informed nursing group must run con-
17 currently with other events.

18 Graduate education for nurses can be begun
19 now. Since this form of education must for the
20 present be secured outside of Canada, obstacles in
21 the way of attendance at American universities must
22 be overcome.

23 In New Brunswick, all nursing effort is
24 composed of nurses from our French as well as our
25 English culture. In any planning for the future,
26 care must be exercised to see that the needs of
27 nurses representing both cultures are met.

28 If the necessary financial support can be
29 secured, at least one demonstration in all the
30 areas of nursing can be in existence within a few

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1 years. Such a possibility is obviously dependent
2 upon the course of events. It is estimated that
3 a ten-year period of research and demonstration
4 will provide the necessary amount of time to find
5 the solutions we are seeking.

6 During this period, every opportunity for
7 observation would be available to other provinces,
8 especially the Atlantic Provinces.

9 As solutions to problems are demonstrated,
10 we have enough faith in the future to predict that
11 proper authorities and appropriate institutions
12 will make sensible use of results.

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17 Fredericton, N. B.
18 November 1957
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 proper authorities and appropriate institutions
 will make sensible use of results.

Frederick, N. J.



Appendix XIII.

A Brief

on

Necessary Nursing Service

To

The New Brunswick Interim Committee on

Hospital Insurance

From

The New Brunswick Association of Registered Nurses

Fredericton, N. B.

February 24, 1958.



Necessary Nursing Service

To

The New Brunswick Inform Committee on

From

The New Brunswick Association of Registered Nurses

Fredericton, N. B.



1 "NECESSARY NURSING SERVICE"

2
3 Introduction:

4
5 Bill 320, or the Hospital Insurance and
6 Diagnostic Services Act, provides in paragraph 2,
7 section f, sub-section ii, for "necessary nursing
8 service." It is to this provision which the New
9 Brunswick Association of Registered Nurses wishes to
10 address itself.

11 Our Association is an incorporated body, in-
12 corporated under the New Brunswick Companies Act.
13 Among the many roles played by our Association is that
14 of the maintenance of standards in nursing service and
15 nursing education. The remarks contained herein re-
16 present principles and opinions presently known to be
17 held by us in this regard.

18 We wish to make the observation that the
19 time placed at our disposal for the preparation and
20 presentation of our brief has been insufficient to
21 permit of the study of many of those questions
22 specified by the Interim Committee. This is to be
23 regretted, when one considers the importance of
24 hospital insurance to the people of our province. On
25 the other hand, we consider that the points as pre-
26 sented by our Association are of importance to our
27 people. We trust that you will give them your
28 serious consideration.

29 Nursing Service:

30 Nursing service in its broadest sense may be



Introduction

Bill 380, or the Hospital Insurance and Diagnostic Services Act, provides in paragraph 2, section 7, sub-section 11, for "necessary nursing service." It is to this provision which the New Brunswick Association of Registered Nurses wishes to

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specified by the Interim Committee. This is to be regretted, when one considers the importance of hospital insurance to the people of our province.

It is hoped that the importance of hospital insurance to our people is of sufficient importance to our people. We trust that you will give them your serious consideration.

Nursing Service

Nursing service in its broadest sense may be



1 defined as the coordinated efforts of a nursing team
2 to participate in meeting the health needs of in-
3 dividuals or groups through the application of the
4 principles of the art and science of nursing.

5
6 Quality of Nursing Service:

7 A high quality of nursing service is dependent
8 upon good programmes of nursing education and a well-
9 organized nursing service under sound administration.

10 In order to maintain a high standard of
11 nursing service, we recommend that:

12 RECOMMENDATION 1.

13 all those employed to carry out the duties of
14 professional nurses be graduates of approved
15 schools of nursing, be currently registered in
16 this province, and be members in good standing
17 of the New Brunswick Association of Registered
18 Nurses.

19 We recommend that:

20 RECOMMENDATION II.

21 administrative policies be established which
22 provide for:

- 23 1. a separate nursing service budget prepared
24 by the director of nursing service and her
25 staff;
- 26 2. qualified personnel for all positions, in
27 quantity sufficient to render good nursing
28 service;
- 29 3. the definition of the functions of personnel,
30 with lines of authority and responsibility

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1. a separate nursing service budget prepared by the director of nursing service and for
2. qualified personnel for all positions, in quantity sufficient to render good nursing service;
3. the definition of the functions of personnel with lines of authority and responsibility



- 1 clearly defined;
- 2 4. a system of communications (including records
- 3 and reports) which will facilitate and en-
- 4 courage good human relations among personnel,
- 5 with patients, their families, and the public
- 6 at large;
- 7 5. the use of the nursing team, as a method of
- 8 providing nursing care when it is appropriate;
- 9 6. the best facilities, equipment, and supplies,
- 10 and the maintenance of these in good working
- 11 condition;
- 12 7. the delegation of appropriate responsibility
- 13 for the supervision of less qualified personnel;
- 14 8. the establishment and regular review of
- 15 personnel policies, using as a guide the
- 16 current recommendations of the New Brunswick
- 17 Association of Registered Nurses in relation
- 18 to:
- 19 (a) orientation, continuous staff organiza-
- 20 tion, evaluation;
- 21 (b) hours of work;
- 22 (c) health practices;
- 23 (d) leaves of absence (vacations, sickness,
- 24 statutory holidays, further study, etc.);
- 25 (e) salaries;
- 26 (f) residence;
- 27 (g) pension plans.

28 When Hospital Insurance is established in this
29 province, we recommend that:
30



and reports; which will facilitate and en-
with patients, their families, and the public
at large;

5. the use of the nursing team, as a method of providing nursing care when it is appropriate;
6. the best facilities, equipment, and supplies, and the maintenance of these in good working order;
7. the delegation of appropriate responsibility for the supervision of less qualified personnel;
8. the establishment and regular review of personnel policies, using as a guide the

current recommendations of the New Association

Association of Registered Nurses in relation

to:

- (a) orientation, continuing self education;
- (b) hours of work;
- (c) health practices;
- (d) leaves of absence (vacation, sickness, etc.);
- (e) salaries;
- (f) retirement;
- (g) pension plans.

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1 RECOMMENDATION III.

2 nursing direct and administer the province of
3 necessary nursing service within such a programme.

4 If quality nursing service is to be provided,
5 maintained and promoted, provision should be made for
6 continuous professional growth within the profession.

7 To this end, we recommend that:

8 RECOMMENDATION IV.

9 (a) generous provision be made under the health
10 insurance plan and within the policy making
11 rights of the administrators of the plan for
12 advanced professional education in nursing
13 in all its various forms;

14 (b) support, including financial support under
15 appropriate conditions of jurisdiction, be
16 given to the New Brunswick Association of
17 Registered Nurses in their efforts to provide
18 continuing education for its members, e.g.,
19 the holding of institutes, conferences, and
20 similar endeavor, the provision of consultant
21 services to the hospital and health agencies,
22 the channeling of professional education to
23 the "grass roots" of our organization, i.e.,
24 our chapters.

25 In order to insure that standards in nursing
26 service be maintained, we recommend that:

27 RECOMMENDATION V.

28 the New Brunswick Association of Registered Nurses
29 be represented at the highest policy making and
30 administrative level of the hospital insurance plan.



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If quality nursing service is to be provided,
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RECOMMENDATION IV.

- (a) Generous provision be made under the health
insurance plan and within the policy making
rights of the administrators of the plan for
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in all its various forms;
- (b) support, including financial support under
appropriate conditions of jurisdiction, be
given to the New Brunswick Association of
Registered Nurses in their efforts to provide
the holding of institutes, conferences, and
similar endeavor, the provision of continuing
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the channeling of professional education to
the "grass roots" of our organization, i.e.,
our chapters
in order to insure high standards in nursing
service be maintained, we recommend that:

the New Brunswick Association of Registered Nurses
be represented at the highest policy making and



1 Nursing Education:

2 Although nursing service and nursing education
3 have two distinct functions, the interdependence of
4 both must be conceded. Under the present system in
5 New Brunswick, nursing education at the pre-specialization
6 level is controlled, managed, and financed by hospitals.
7 To tie anything as fragile and precious as an education-
8 al system to the per diem cost of hospital care con-
9 tains obvious dangers. Not the least of the dangers is
10 the one that so obviously involves the quality of
11 nursing service. For this reason, the lack of
12 special provision in Bill 320 for the financing of
13 nursing education causes the New Brunswick Association
14 of Registered Nurses grave concern. In this respect
15 we desire to be explicit. The danger in our tradition-
16 al system lies in the very real possibility of conflict
17 in interest between the needs of the hospital for
18 service and the needs of the student for education.
19 We can anticipate a heavy demand for service in the
20 early years of implementation of any health insurance
21 scheme. If there is a sacrifice of educational needs
22 to service needs, the quality of service decreases in
23 ratio to the decrease in quality of education. Of all
24 the points we are endeavoring to make in this brief,
25 this is in our opinion the most important. We earnestly
26 request that you give careful attention to its signifi-
27 cance. Our concern is expressed on behalf of a public
28 which does not seem to understand well the intricacies
29 of nursing education within the present system of
30 nursing service.

Although nursing service and nursing education

have two distinct functions, the interdependence of both must be considered. Under the present system in New Brunswick, nursing education at the pre-hospital level is controlled, managed, and financed by hospitals. To tie anything as fragile and precious as an educational system to the per diem cost of hospital care contains obvious dangers. Not the least of the dangers is the one that so obviously involves the quality of nursing service. For this reason, the lack of special provision in Bill 22 for the financing of nursing education causes the New Brunswick Association of Registered Nurses grave concern. In this respect we desire to be explicit. The danger in our tradition of system lies in the very real possibility of conflict in interest between the needs of the hospital for service and the needs of the student for education. We can anticipate a heavy demand for service in the early years of implementation of any health insurance scheme. If there is a shortage of educational needs to service needs, the quality of service delivered in ratio to the decrease in quality of education, for all the points we are endeavoring to make in this brief this is in our opinion the most important. We respectfully request that you give careful attention to this significant. Our concern is expressed on behalf of a public which does not seem to understand well the interdependence of nursing service and nursing education.



1 In this regard, we recommend the Canadian
2 Nurses' Association Policies on Education, which are
3 as follows:

4 RECOMMENDATION VI.

- 5 1. The preparation of the nurse should be an
6 educational experience and the method by
7 which this can best be achieved is through
8 a school which plans and controls the com-
9 plete experience of the student.
- 10 2. The education of all categories of nursing
11 personnel is the responsibility of the pro-
12 fessional group.
- 13 3. The curriculum for the preparation of any
14 category of nursing personnel should be an
15 evolving one, subject to continuous review.
- 16 4. All those charged directly or indirectly
17 with the education of students should be
18 specially qualified, both professionally and
19 personally, for their responsibilities.
- 20 5. Nursing requires and has the right to expect
21 public and private financial support of its
22 education.

23 Public financial support of nursing
24 education should be dependent upon:

- 25 (i) presentation of a budget by a
26 school of nursing;
- 27 (ii) statement of the disposition of
28 public funds designated as ed-
29 ucational grants;
- 30 (iii) the maintenance of educational

1. The preparation of the nurse should be an educational experience and the method by which this can best be achieved is through a school which plans and controls the complete experience of the student.
2. The education of all categories of nursing personnel is the responsibility of the professional group.
3. The curriculum for the preparation of any category of nursing personnel should be an evolving one, subject to continuous review.
4. All those charged directly or indirectly with the education of students should be specially qualified, both professionally and personally.
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- education should be dependent upon:
- (i) presentation of a budget by a school of nursing;
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standards.

Public financial support should be dispensed through educational institutions. Where hospital schools of nursing are deemed to be appropriate educational institutions by the New Brunswick Association of Registered Nurses, financial aid should be granted on the basis of the cost of the educational programme.

Provision should be made for financial help in developing new educational programmes, both outside and within the hospital milieu.

Schools of Nursing:

It would be disastrous to the quality of nursing service were hospitals to establish or maintain schools of nursing under conditions of inadequacy.

We recommend that:

RECOMMENDATION VII.

hospital schools of nursing be associated with hospitals whose minimum daily average does not fall below one hundred; that hospital schools of nursing be accredited by the national accrediting agency when one is established; that only approved hospital schools of nursing be supported in any way under the hospital insurance scheme.

Systems of nursing education other than the traditional hospital school should be set up in this province. As an immediate step in this direction, we recommend that:

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province. As an immediate step in this direction,

we recommend that:



1 RECOMMENDATION VIII.

2 the University of New Brunswick be supported in
3 all appropriate ways in its efforts to establish
4 a demonstration programme in nursing education.

5 We further recommend that reasonable experimental
6 programmes in nursing education be supported.

7 Quantity of Nursing Service:

8 Mention has been made of the anticipated
9 increase in demand for nursing service. To meet this
10 quantitative demand, there must be an increase in the
11 number of nurses available for service. Support to
12 our recommendations with respect to education will go
13 a long way to insure supply. So will attractive
14 personnel policies. The New Brunswick Association of
15 Registered Nurses makes every effort to present fair
16 and just personnel policies. These policies are
17 amended from time to time with changes in the economy.

18 We recommend that:

19 RECOMMENDATION IX.

- 20 (a) all hospitals participating in the insurance
21 scheme adhere to the minimum personnel
22 policies of the New Brunswick Association of
23 Registered Nurses;
- 24 (b) there be no restrictions placed on any hospital
25 to go beyond the minimum policies of the New
26 Brunswick Association of Registered Nurses;
- 27 (c) the New Brunswick Association of Registered
28 Nurses have arbitration rights and privileges
29 in any question involving open dispute within
30 any participating hospital on matters pertain-



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Quantity of Nursing Services:

Mention has been made of the anticipated increase in demand for nursing services. To meet this quantitative demand, there must be an increase in the number of nurses available for service. Support to our recommendations with respect to education will go a long way to insure supply. So will attractive personnel policies. The New Brunswick Association of Registered Nurses makes every effort to present fair and just personnel policies. These policies are amended from time to time with changes in the economy. We recommend that:

RECOMMENDATION IX.

- (a) All hospitals participating in the Insurance scheme adhere to the minimum personnel policies of the New Brunswick Association of Registered Nurses;
- (b) there be no restrictions placed on any hospital to go beyond the minimum policies of the New Brunswick Association of Registered Nurses;
- (c) the New Brunswick Association of Registered Nurses have arbitration rights and privileges in any question involving open dispute within

1 ing to nursing service.

2 General Comments:

3 The Hospital Insurance and Diagnostic
4 Services Act states that "the Province shall covenant
5 and agree to make insured services available to all
6 residents of the Province upon uniform terms and con-
7 ditions." The New Brunswick Association of Registered
8 Nurses subscribes to the principle of universal
9 coverage in hospital services.

10 In order to insure that all residents receive
11 equality of distribution of nursing service, we
12 recommend that:

13 RECOMMENDATION X.

14 the New Brunswick plan provide for coverage of the
15 entire population of the Province without regard
16 to the economic status of the individual (This
17 principle refutes the premium system referred to
18 in the questionnaire of the Interim Committee.).

19 It is our opinion that a representative
20 citizens group or commission, separate and apart from
21 any existing department of the government or other
22 institution in our society, should be created for the
23 specific purpose of setting policy. We have already
24 recommended that we have representation at this level
25 of administration.

26 Some clarification is required with respect to
27 the services of the private or special duty nurse,
28 since Bill 320 provides for "necessary nursing service."
29 In the event that the attending physician states in
30 writing that special or "private" nursing care is re-



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Some clarification is required with respect to
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since Bill 380 provides for "necessary nursing services."
In the event that the attending physician states in
writing that special or "private" nursing care is re-



quired for the patient, we recommend that:

RECOMMENDATION XI.

the cost of such nursing care be a legitimate charge to the hospital service (If the patient desires special or "private" nursing care, the cost of this type of service should be borne by the patient.).

Conclusion:

The efforts of the New Brunswick Interim Committee on Health Insurance cannot fail to be of great value to the people of our province. Your careful consideration of the many briefs before you involves you in a public service of great magnitude. Please be assured that the brief of the New Brunswick Association of Registered Nurses carries with it our conviction that the points and recommendations contained herein are in the best interest of the people of our province. We offer you our cooperation, especially in the all-inclusive area of nursing service.

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especially in the all-inclusive area of nursing services.



1 THE CHAIRMAN: Thank you, Miss MacLaggan.

2 MR. HALL: Miss MacLaggan, could you
3 tell us what the existing programme at the University of
4 New Brunswick School of Nursing is?

5 MISS MacLAGGAN: Mr. Hall, do you
6 mean with reference to the continuing education programme,
7 or the whole programme?

8 MR. HALL: The whole programme.

9 MISS MacLAGGAN: At present we conduct
10 two programmes. One is the under-graduate programme. It
11 is a degree-conferring programme. In our philosophy it
12 involves in content general education and professional
13 education. At the conclusion of the programme the
14 candidates will qualify for registration in the Province
15 of New Brunswick and will be awarded a Bachelor of Nursing
16 degree. In the body of the brief we describe in some
17 detail what a professional nurse is, what the role of the
18 professional nurse is, and we feel that in the programme
19 at the University of New Brunswick we are creating this
20 professional nurse.

21 The second programme is the continuing
22 education programme which we refer to in our recommendations.
23 It is for graduate nurses. It consists of short courses
24 anywhere from one to six weeks in duration, and deals with
25 the variety of topics which have been requested of us by
26 the nurses of New Brunswick.

27 MR. HALL: How many students are
28 presently enrolled?

29 MISS MacLAGGAN: We have forty-two
30 students in our school. We started, as of this September,



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presently enrolled?

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in our school. We started, as of this September,



1 our third year. We have not yet graduated any students.
2 MR. HALL: Is it the intention of
3 your Association as part of its recommendations to re-
4 commend a change in the present status of diploma schools
5 of nursing now operated by the hospitals of the province?

6 MISS MacLAGGAN: In our summary we
7 did not recommend any change in status in the present
8 group graduating from hospital schools. We recommend
9 hospital schools cease to exist and another form of
10 nursing education be offered.

11 MR. HALL: In that event, what will
12 be the future status of the graduate nurses who have been
13 educated in the present diploma schools?

14 MISS MacLAGGAN: I would think, Mr.
15 Hall, that their status will be secure in their self-
16 image of professionalism and in the public's concept of
17 their professionalism. However, I believe that time --
18 perhaps a generation -- will resolve any status problems
19 or status symbols that might exist if there is a properly
20 controlled transition from this system of education to
21 a newer system evolved.

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1 MR. HALL: Your recommendation No.

2 6. You recommend a study of the present status of nursing
3 in our culture. Would you tell us particularly what you
4 mean by that?

5 MISS MacLAGGAN: Yes, sir. By this
6 we mean the cultural image of nursing, the nature of our
7 legal position, the position of nurses in nursing affairs,
8 the financial conditions affecting nurses, and nursing.

9 MR. HALL: I think you also said in
10 part of your brief that all the big decisions in nursing
11 have to do with structure and the big decisions are not
12 made by nurses for nursing. What do you mean by that?

13 MISS MacLAGGAN: We would describe
14 the big decisions as decisions which have to do with
15 staffing, and quality, but particularly quality of nursing
16 service, budgeting and all things pertaining to staffing.
17 We would include in that education and the whole system
18 of education, and this use of the student nurse group as
19 the labour force; and would also include reference to
20 legislation, and we have given some examples. Included
21 in legislation -- we are using this in its broadest sense,
22 we would refer to criteria for the measurement of
23 standards. We have no administrative voice with respect
24 to an advisory committee to the Department of Health
25 Service. Since the writing of this brief such an advisory
26 committee has been formed in New Brunswick. We have no
27 nurse in the Province of New Brunswick with even an
28 administrator designation, and we have no education under
29 our hospital schools with the director who is separate
30 and apart from service. We have a very limited voice

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and apart from service. We have a very limited voice



1 at this legal level on the behalf of the people of Canada
2 for necessary nursing service.

3 MR. HALL: Are you implying that the
4 decisions in regard to structure should be made by the
5 nurses alone?

6 MISS MacLAGGAN: No, not necessarily
7 in some instances. In some instances that would not be
8 in the best interests of the patient. But we think we
9 do have a valuable voice which could be heard and should
10 be heard if we are to bring the best patient care to the
11 public.

12 MR. HALL: And recommendation No. 9,
13 page 3, in regard to the first part of recommendation No.
14 9. If the Executive Director or Administrator of a
15 hospital is not a registered nurse, in your view it
16 should be Director of Nursing have direct access to the
17 Board of Trustees of the hospital without prior consul-
18 tation with the Administrator?

19 MISS MacLAGGAN: I would think, sir,
20 that prior consultation, if the relationship is good,
21 should always go on. I feel that it would be in the
22 interests of better patient care if nurses did interpret
23 particularly upon vital occasions direct to the Board.

24 THE CHAIRMAN: Would that be the
25 only employee group in the hospital that would be able to
26 go over the head of management in this way?

27 MISS MacLAGGAN: Sir, I would not
28 see this as a mechanism whereby nursing went over the
29 head of management. I would see this task being carried
30 on as a staged opportunity for a nursing interpretation,



1 since nursing is the big item in any hospital situation,
2 and that she would merely interpret the thing and withdraw
3 from any decision of the Board or the administration.

4 COMMISSIONER GIRARD: Mr. Chairman,
5 I would like to start out by congratulating the nurses
6 of New Brunswick on this very extensive brief. I believe
7 it is thought-provoking, and in the state where nursing
8 is today, I believe we should give some thought as to the
9 direction nursing will take in order to be able to
10 fulfill its role in society as it would want to fulfill
11 its role.

12 There are a great many question marks
13 posed here, Miss MacLaggan. I will try to draw them for
14 you. I know we cannot elaborate on every one of them,
15 and some would have a great impact on nursing, and,
16 Miss MacLaggan, you have answered already some of the
17 questions that I had in mind.

18 In your summary, item No. 5, you say:

19 "The structure of nursing education and nursing
20 service need priority action, to wit:

21 1. the number of students in professional schools
22 of nursing in the university should be increased
23 by eight to ten times the present number."

24 First, would you tell me on what
25 basis you arrived at this figure of eight to ten times
26 the number that there is already?

27 MISS MacLAGGAN: We have forty-two
28 students at the present time at university level in New
29 Brunswick; we have some eight hundred student nurses in
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 you. I know we cannot elaborate on every one of them,
 and some would have a great impact on nursing, and
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 questions that I had in mind.

In your summary, item No. 2, you say:
 "The structure of nursing education and nursing
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 by eight to ten times the present number."

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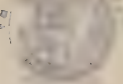


1 thousand students of nursing in schools across Canada.
2 Our statistical breakdown in appendix 2 indicates that
3 approximately twenty-five per cent of girls who presently
4 chose nursing are in the upper academic group. In other
5 words, they have demonstrated with one measure that they
6 are potentially professional people, and in working your
7 arithmetic out on that basis, if twenty-five per cent of
8 the girls who are presently motivated to nursing, then
9 we feel they should be getting this kind of education,
10 because the patient and society needs them, and this works
11 out to eight to ten times the number we have, and I
12 submit, Miss Girard, that this probably applies across
13 Canada.

14 COMMISSIONER GIRARD: Thank you.
15 Along the same line later on you state that students who
16 have marks of seventy per cent and over should be in the
17 university. Can we know what makes you decide that the
18 seventy per cent is the mark that students should have,
19 that students who have seventy per cent should be in
20 university?

21 MISS MacLAGGAN: Well, I say that a
22 mark is one measure only, and it seems to be the criterion
23 which we use in education. I don't for a moment think
24 it is the only measure, I think that we put a qualifying
25 adjective in there somewhere. One would have a reasonable
26 expectation that these students have seventy-five per
27 cent or over possess the human ability to accept, absorb
28 and profit from university education.

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1 group of nursing personnel or the unnamed group. Could
2 you give us your philosophy or your thinking along the
3 lines of where this second group would be placed and how
4 it would function in relation to the first group which
5 should be the professional group?

6 MISS MacLAGGAN: On page 16 of the
7 brief we have projected the role of this person, Miss
8 Giarard. Would you like me to restate the ----

9 THE CHAIRMAN: It is in the brief;
10 it is mentioned there?

11 MISS MacLAGGAN: It is in the brief,
12 in detail. We have projected the role of the technical
13 or clinical, if you like, still to be named.

14 COMMISSIONER GIRARD: This to my
15 point of view is one of the major decisions to be taken
16 in nursing.

17 MISS MacLAGGAN: Yes. In order to
18 bring it before the Commission, I would like to make the
19 point that we see these technical nurses or clinical
20 nurses coming from some of the group that presently goes
21 into the Hospital School of Nursing, and some of that
22 group that we have legally designated in the province as
23 the nursing assistant group, and we have provided you
24 with statistics to show you the percentage of women who
25 presently come into this nursing assistant group, who have
26 high school graduation to the grade twelve level, and we
27 have shown you statistics on the numbers of people who
28 come into nursing with marks between fifty per cent and
29 seventy per cent.

30 We have counted our statistics and

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1 arrived at the conclusion that a four to one ratio of
2 people are already coming into nursing who could be this
3 technical or clinical nurse, given the educational
4 opportunity by the State.

5 COMMISSIONER GIRARD: Miss MacLaggan,

6 I wonder if you would mind giving your point of view on
7 a question that was posed yesterday in relation to the
8 Department of Health brief. It was rather a surprise to
9 learn that there were over average persons in nursing in
10 hospitals in New Brunswick. Would you concur with this
11 or would you have any further information to give on this?

12 MISS MacLAGGAN: Miss Girard, I

13 think it was a shock to the New Brunswick Nurses'
14 Association to learn that we were in this happy state of
15 affairs. It is nice to find one area of wealth in the
16 Province of New Brunswick. I would use this as a case
17 in point with reference to lack of voice which nurses have
18 in regard to structuring of all big decisions. I would
19 like to know from the Department of Health how this measure
20 was made in terms of excess of nurses working in our
21 hospitals, I would like to know what the measure of
22 quality of service was. I think we would have to know
23 how this figure was arrived at. And then the Department
24 of Health presenters referred to the Canada Year Book
25 and a certain table, and this motivated us to follow this
26 through, and we do not find the same interpretation from
27 the Canada Year Book.

28 For example, it says here:

29 "Provincially the total staff of nursing personnel
30 ratios were highest in Ontario for general hospitals,

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28 ratios were highest in Ontario for general hospitals."



1 in Newfoundland for mental institutions, and in
2 Nova Scotia for other hospitals."

3 We must conclude also that this
4 statistic is a variety of nursing personnel and part-time
5 workers, and there must be some explanation for this
6 state of affairs. Then, we have in our province many
7 small hospitals, and presumably if you have one baby in
8 one nursery you must have one nurse around the clock.
9 There are all these items which must be taken into consi-
10 deration before we can quite properly conclude that we
11 have an excessive number of nurses being employed in New
12 Brunswick.

13 COMMISSIONER GIRARD: Thank you very
14 much. Perhaps that will make other nurses in the other
15 provinces feel better.

16 On page 5, Part III, pertaining to
17 legislation, this paragraph deals with the daily average
18 of patients or the number of beds a hospital should have
19 in order to conduct a school of nursing. What in your
20 estimate, Miss MacLaggan, would be the minimum number of
21 beds or the minimum number of daily average patients in
22 order to conduct a school of nursing in such a way that
23 the students could get good experience?

24 MISS MacLAGGAN: May I refer the
25 answer to that question to a quick look at our appendix
26 1, Enrolment in hospital schools of nursing in New
27 Brunswick, where we have shown you quickly the bed
28 capacity, the student enrolment, and where our students
29 of nursing are placed. It would seem that we have to
30 look at the distribution of our human and physical



in Newfoundland for mental institutions, and in Nova Scotia for other hospitals."

We must conclude also that this

statistic is a variety of nursing personnel and part-time

workers, and there must be some explanation for this

state of affairs. Then, we have in our province many

small hospitals, and presumably if you have one baby in

one nursery you must have one nurse around the clock

There are all these items which must be taken into consid-

eration before we can quite properly conclude that we

have an excessive number of nurses being employed in New

Brunswick.

COMMISSIONER GIBBARD: Thank you very

much. Perhaps that will make other nurses in the other

provinces feel better.

On page 5, Part III, pertaining to

of patients or the number of beds a hospital should have

in order to conduct a school of nursing. What in your

estimate, Miss MacLagan, would be the minimum number of

beds or the minimum number of daily average patients in

order to conduct a school of nursing in such a way that

the students could get good experience?

MISS MACLAGAN: May I refer the

answer to that question to a quick look at our appendix

1. Enrolment in hospital schools of nursing in New

Brunswick, where we have shown you quickly the bed

capacity, the student enrolment, and where our students

look at the distribution of our human and physical



1 resources in the field of education, and perhaps if our
2 legislation could be brought forward to eliminate the
3 wastage. I don't know that we are able to answer you
4 directly on that point, but the evidence is in this brief.

5 COMMISSIONER GIRARD: Thank you very
6 much, Miss MacLaggan.

7 COMMISSIONER BALTZAN: Miss MacLaggan,
8 if this is not contained in the brief, my first question
9 is: what are the main reasons for the abolition of the
10 traditional nurses' training school?

11 MISS MacLAGGAN: Sir, may I have the
12 question again?

13 COMMISSIONER BALTZAN: What are your
14 main reasons for doing away with the present hospital
15 training schools for nurses and have them only as degree
16 courses?

17 MISS MacLAGGAN: Sir, I wouldn't for
18 a moment suggest that we have only the degree courses in
19 nursing. As a matter of fact, we suggest in our brief
20 that we should have four times the number of technical or
21 clinical nurses to professional nurses who are trained in
22 university.

23 In answer to your question why we
24 should recommend this change, all is not well in nursing.
25 We will back with analysis the reasons why all is not well
26 in nursing. We have come to the conclusion that there are
27 many flaws in our nursing education, in the situation which
28 has produced the impasse where we find ourselves in.
29 We are dealing specifically with the philosophy of nursing
30 education. We feel that with one hundred years of nursing,



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COMMISSIONER GIRARD: Thank you very
much, Miss MacLellan.
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is: what are the main reasons for the abolition of the
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MacLaggan

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1 the nurses expect a better education from society rather
2 than through the labour which we must return ourselves
3 for our education. It is a recognition that the system
4 has not done what it should have done in terms of providing
5 the type of person to give patient care in our country.

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1 COMMISSIONER BALTZAN: Miss MacLaggan,

2 I support entirely your philosophy. There is a move in
3 some quarters, some parts of the country, where consider-
4 ation is being given to the reduction of the registered
5 nurses' curriculum from three years to two years. May
6 we have your opinion in that regard?

7 MISS MacLAGGAN: We have mentioned
8 in our brief, sir, and we concur with the findings of
9 the Lord Report on the study of the metropolitan school
10 which the Canadian Registered Nurses Association did
11 undertake. We concur with all those findings.

12 COMMISSIONER BALTZAN: Your local
13 opinion is that in this province. Thank you very much.

14 COMMISSIONER McCUTCHEON: I have
15 one question, just as a matter of whether I understand
16 these schedules. I am looking at appendix 8. Do the
17 statistics in these appendices refer only to nurses,
18 nurses' assistants, and nurses' aides, and students in
19 nursing? In other words, total professional personnel,
20 does that include anything other than nurses?

21 MISS MacLAGGAN: Total professional
22 personnel, that is registered nurses only. Student
23 nurses is clear. We don't know what the Department of
24 Health has included under non-professional personnel.

25 COMMISSIONER McCUTCHEON: So there
26 may be ward aides and ----?

27 MISS MacLAGGAN: The registered
28 nursing assistant group, and ward aides, and any person
29 that the hospital employs in the nursing service.

30 COMMISSIONER McCUTCHEON: So this



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COMMISSIONER MCGILL: So this



1 final figure under 1960, at the right hand side of the
2 column, means that on the basis of the calculation which
3 you have footnoted, we will say that in hospital E that
4 25 per cent of the care was provided by student nurses,
5 is that right?

6 MISS MacLAGGAN: That is correct.

7 COMMISSIONER McCUTCHEON: And that
8 is what you refer to when you refer to wanting a change
9 in system, so that you wouldn't have to pay for your
10 education by repaying it in work?

11 MISS MacLAGGAN: Yes sir. We feel
12 that that is an unsound system, and perhaps even an
13 immoral one.

14 COMMISSIONER McCUTCHEON: I am not
15 a very good judge of morals, but let me put it this way.
16 What practical training, what clinical training do the
17 girls in your school obtain, how is that arranged?

18 THE CHAIRMAN: The university schools.

19 MISS MacLAGGAN: Spread over a four-
20 year period, we feel that the time in the clinical field
21 under supervised experience by our faculty is going to
22 work out to twelve months.

23 COMMISSIONER McCUTCHEON: That is
24 spread ----

25 MISS MacLAGGAN: Spread over four
26 years. It is a longer year than the regular academic
27 year. The year begins in September and ends the end of
28 June, which is longer than the traditional university
29 year, and the amount of time taken out over this four
30 year period for clinical experience in the total clinical



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1 field, this includes the hospital and public health, we
2 think is working out to almost exactly twelve months.

3 COMMISSIONER McCUTCHEON: Would any
4 of your students be included in these statistics?

5 MISS MacLAGGAN: No sir.

6 THE CHAIRMAN: In that twelve month
7 period, do the students receive pay when they are working
8 in this clinic, having this clinical experience?

9 MISS MacLAGGAN: No sir. This is
10 an educational experience, and therefore, any monetary
11 equation does not enter into it.

12 COMMISSIONER McCUTCHEON: In the
13 summary, page 13, you say you believe that the cost item
14 to the individual should be removed from the freeplay
15 of the price mechanism. Later on, you suggest that
16 there be no ceiling on a certain class of nursing salaries,
17 that the nurse should be rated higher, so I am just
18 wondering what you mean. There seems to me to be some
19 inconsistency. Who is going to determine these matters?

20 MISS MacLAGGAN: We have said also,
21 sir, on page 6:

22 "We believe that the value which society
23 places on a given role should be reflected
24 in the income gained from that role"

25 And furthermore, that nursing salaries be equated through
26 the responsibility, service, preparation and status. So,
27 in an economy such as ours, we assume that a proper and
28 fair remuneration for nursing can be found, and we refer
29 to ceiling with reference to the practitioner of nursing,
30 because we have a system in the province at the present



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And furthermore, that nursing salaries be equated through

the government with the salaries of other professions

in an economy such as ours, we assume that a proper and

equitable distribution of income is essential for the

well-being of the community and the health of the

individual.



1 time that permits the nurse who works as a general
2 practitioner to be paid the lowest salary in the hierarchy
3 of salaries. The general staff nurse she is called, and
4 I think her salary is recommended as \$270.00 with a
5 ceiling of something like \$320.00, and surely, if we are
6 to bring to the bedside of the patient the very best that
7 we have in nursing service, we should be paying some of
8 our highest salaries to the people who are working on a
9 face-to-face basis with the patient. At the present time,
10 at no place in Canada does the society permit this to
11 happen. The reverse is true for the medical profession.

12 COMMISSIONER McCUTCHEON: In other
13 words, you would approve that you should have more control
14 over your own remuneration?

15 MISS MacLAGGAN: Yes, sir, but may
16 I add that I see no conflict in our general philosophy
17 when we say that we believe that the cost item to the
18 individual should be removed from the freeplay of the
19 price mechanism, and our stand with reference to re-
20 muneration to nurses.

21 COMMISSIONER McCUTCHEON: What do you
22 mean by removal from the freeplay of the price mechanism?

23 MISS MacLAGGAN: Well, this is a
24 blanket umbrella for us, sir, with reference how all these
25 health services are to be paid. We haven't said whether
26 we think this should be an all-inclusive government plan,
27 or some premium system, or the like, but we have stated
28 the general principle that any health service, regardless
29 of what it is, should be removed from the freeplay of
30 the price mechanism. I think it is a principle, and I



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1 think you can apply the examples, sir.

2 COMMISSIONER McCUTCHEON: You have
3 recommended that the hospital care scheme be extended
4 to cover mental institutions, I believe?

5 MISS MacLAGGAN: Yes, sir.

6 COMMISSIONER McCUTCHEON: Should
7 be extended to cover nursing care in the home, is that
8 what you have in mind?

9 MISS MacLAGGAN: Yes, sir.

10 COMMISSIONER GIRARD: Mr. Chairman,
11 one more question. Since at the present time, because
12 of the shortage of nurses we are dependent quite largely
13 on married nurses, there is a recommendation here on
14 page 7, number 20:

15 "Our government services discriminate against
16 married women who work in terms of salary,
17 tenure, superannuation, and holiday time."

18 What would be the discrimination against married women
19 in terms of salary? I can see the others, superannuation
20 and holiday time. If they are part time they might not
21 be getting it. What would it be in terms of salary?

22 MISS SMITH: Miss Girard, I might
23 say there has been a change, but married women in the
24 civil service, we have grades, the married women start
25 at the minimum, the lowest of the grades, and there have
26 been no increases in this. After a period of time in the
27 organization in which they work a recommendation comes
28 through.

29 THE CHAIRMAN: Are you speaking now
30 of nurses, pardon me?



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and holiday time. If they are part time they might not

be getting it. What would it be in terms of salary?

MISS SMITH: Miss Girard, I might

say that the salary of married women is lower than that of single women.

Also, married women are not eligible for superannuation and holiday pay.

At the same time, married women are not eligible for the same pension as single women.

There are many instances of married women who are not getting the same treatment as single women.

For example, a married woman who works for the government and is not eligible for superannuation.

THE CHAIRMAN: Are you speaking now

of nurses, pardon me?



1 MISS SMITH: I am speaking of nurses,
2 yes, and there has been no increase in salary. They
3 would stay at the minimum, and through the mechanism
4 of recommendations we could get them perhaps, up to the
5 minimum of the next grade. Just recently there has been
6 an increase in salary, but they still do not have the
7 benefit of sick leave, nor are they on superannuation.
8 They are still temporary employees.

9 COMMISSIONER GIRARD: Thank you,
10 Miss Smith, but does this still apply only to civil
11 servants?

12 MISS SMITH: Yes.

13 COMMISSIONER GIRARD: Not in hospitals?

14 MISS SMITH: Well, to hospitals
15 under the government.

16 COMMISSIONER McCUTCHEON: Are these
17 people working full time, or do they work as they choose?

18 MISS SMITH: Oh, no, full time.

19 THE CHAIRMAN: Thank you very much,
20 Miss MacLaggan and ladies.

21 The Canadian Mental Health Association,
22 New Brunswick Division. This will be number 45.

23 --- EXHIBIT NO. 45: Submission of the
24 New Brunswick Division
25 of the Canadian Mental
26 Health Association.
27
28
29
30



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EXHIBIT NO. 45:

Submission of the
New Brunswick Division
of the Canadian Mental
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SUBMISSION

of

THE NEW BRUNSWICK DIVISION

of

THE CANADIAN MENTAL HEALTH ASSOCIATION

APPEARANCES:

Travis W. Cushing,	President
R. A. Craig,	First Vice President
Royden D. Cosman,	Secretary

MR. CUSHING: Mr. Chairman, ladies and gentlemen, I am speaking for the New Brunswick Division of the Canadian Mental Health Association. I will introduce our body very briefly. I understand the Commission is closing the sitting very shortly. We are one division of the Canadian Mental Health Association, and the brief we presented is one of nine briefs which you will hear across the country, and our National organization will present a brief to you at your Ottawa sitting.

This Division of the Canadian Mental Health Association has fifteen branches and community committees throughout the province of New Brunswick, representing about 15,000 citizens who are active members. We are interested, as you have already heard in Nova Scotia and Prince Edward Island, in the mental health and well-being of the citizens of our province. We are particularly concerned with health services as applied to the mental health field. Here in New

President

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MR. GOSHLING: Mr. Chairman, ladies

and gentlemen, I am speaking for the new Brunswick

Division of the Canadian Mental Health Association.

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the Commission is closing the meeting very shortly.

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We are interested, as you have already heard in Nova

Scotia and Prince Edward Island, in the mental health

and well-being of the citizens of our province. We

are particularly concerned with health services and

applied to the mental health field. Here in New



1 Brunswick we have prepared and submitted to you a brief
2 with recommendations. We hope that these recommendations
3 will represent the views of many of the people of our
4 province. They represent very careful thinking on the
5 part of the executive of the association, and were
6 prepared with advice and assistance from our psychiatric
7 friends and consultants. Since you are short of time,
8 Mr. Chairman, we are prepared to omit the reading of
9 the recommendations.

10 THE CHAIRMAN: No, we have time to
11 hear them.

12 MR. CUSHING: In that case, I will
13 call on Mr. Craig, our vice president to read the
14 recommendations, and then we will be prepared to discuss
15 them.

16 MR. CRAIG:

17
18 FOREWORD

19 The New Brunswick Division of the
20 Canadian Mental Health Association welcomes this oppor-
21 tunity to present to you, Mr. Chairman, and the members
22 of the Royal Commission on Health Services, a submission
23 on behalf of our Board of Directors, all our members and
24 the people of this Province.

25 Our Association is aware of the great
26 need for a general Health Survey on the Health Needs of
27 all Canadians; however, we wish to limit our presentation
28 to the area of immediate concern to this Association,
29 i.e., Mental Health and Mental Illness.

30 The Canadian Mental Health Association



provinces. They represent very careful thinking on the part of the executive of the association, and were prepared with advice and assistance from our physicians, friends and consultants. Since you are short of time, Mr. Chairman, we are prepared to omit the reading of the recommendations.

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MR. CRAIG:

PROCEEDINGS

The New Brunswick Division of the Canadian Mental Health Association welcomed this group of twenty to present to you, Mr. Chairman, and the members of the Royal Commission on Mental Health, a report on behalf of our Board of Directors, all our members and the people of this Province.

Our Association is aware of the great need for a general mental survey on the health of all Canadians, however, we wish to limit our presentation to the area of immediate concern to this Association.



1 is a National, voluntary society of more than 100,000
2 members across Canada, founded in 1918 and now organized
3 into nine Provincial Divisions in all provinces except
4 Newfoundland. This Canada-wide organization now comprises
5 more than 120 local branches. Each of the Provincial
6 Divisions is governed by a volunteer Board of Directors,
7 which in turn is advised by a professional Planning
8 Committee, with representation on the National Board of
9 Directors and the National Scientific Planning Council.
10 The names of members of the New Brunswick Division
11 Provincial Board of Directors, the Scientific Planning
12 Committee and the location of the Provincial Office, are
13 attached herewith.

14 The objects of the New Brunswick
15 Association, following National Policy, are, briefly, to
16 organize and mobilize public support for an all-out
17 attack against Mental Illness, and to help provide
18 scientific guidance in this attack; and its program is
19 directed to four basic areas:

- 20 (1) Public Information and Education.
- 21 (2) Services to the mentally ill.
- 22 (3) Social action in fields of legislation
23 and planning.
- 24 (4) Promotion of scientific research.

25 The New Brunswick Division, along with
26 its branches and community committees, of which there are
27 now fifteen, carries out a variety of programs in the
28 four basic areas. The New Brunswick Division members and
29 supporters, estimated at more than 20,000, are drawn from
30 the cities, towns and rural areas throughout the province.



...the ... of ...

Newfoundland, and Canada-wide organization now comprises more than 150 local branches. Each of the Provincial

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the cities, towns and rural areas throughout the province.



With this brief background, we accept our special responsibility in presenting the following observations and recommendations on behalf of our Association.

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FINANCING	
PREVENTION	



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STATE

THE PROBLEM

NEW PATIENTS OF TREATMENT AND
FACILITIES

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PERMANENT

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RECOMMENDATIONS

1. (a) Every effort should be made to expand mental health facilities in local communities. Any additional beds for psychiatric patients should be provided in psychiatric units in general hospitals rather than in the provincial hospitals. Existing mental health centres should be expanded where necessary, and additional centres provided where population justifies it. These centres would not only provide full out-patient care for adults, but would also serve as child guidance centres. Psychiatric units in general hospitals should not be smaller than 15 beds, and should have the necessary professional psychiatric, nursing, psychological and social work staff. Such a unit would be justified for a region with a population of 70,000 to 100,000 people. (Reference 1).

(b) In terms of New Brunswick's need for psychiatric units in general hospitals, this would mean the establishment of additional psychiatric units in the general hospitals at Fredericton, Edmundston and Bathurst. At least one additional mental health centre is also needed. It should probably be located in Bathurst.

(c) Community mental health centres appear to operate more effectively when a high degree of local autonomy and involvement is provided for, although major financial support must come from provincial and federal funds. Such local autonomy enables the mental health centre to serve the special needs of each area more

RECOMMENDATIONS

mental health facilities in local communities, and additional beds for psychiatric patients should be provided in psychiatric units in general hospitals rather than in the provincial hospitals. Existing mental health centres should be expanded where necessary, and additional centres provided where population justified it. These centres would not only provide full out-patient care for adults, but would also serve as child guidance centres. Psychiatric units in general hospitals should not be smaller than 15 beds, and should have the necessary professional psychiatric, nursing, psychological and social work staff. Such a unit would be justified for a region with a population of 75,000 to 100,000 people.

(b) In terms of New Brunswick's need for psychiatric units in general hospitals, this would mean the establishment of additional psychiatric units in the

At least one additional mental health centre is also needed. It should probably be located in Dalhousie. Community mental health centres appear to operate more effectively when a high degree of local autonomy and involvement is provided for, although major financial support must come from provincial and federal funds. Such local autonomy enables the mental health



effectively.

Careful attention must be paid to the provision of adequate salaries in order to attract and to hold fully qualified psychiatrists in the provincial health services. Current salaries for psychiatrists in New Brunswick are \$3500. to \$5000. below existing rates in adjacent provinces.

We strongly urge the removal from mental hospitals of geriatric and mental defective patients for whom no active treatment is indicated and whose presence in the hospital confuses the issue of treatment and cost of care for the chronic mentally ill patient. It has been observed that where adequate mental health facilities are provided within the community, 75% of new admissions can be treated within their own community. This means a marked reduction in the number of new admissions to provincial hospitals of chronically ill persons, and should enable these hospitals to provide more active treatment for the chronically ill.

We recommend that steps be taken to change the administration of provincial hospitals to resemble more closely that of general hospitals, with each hospital having a board of commissioners to administer its business affairs, and a medical staff responsible for the treatment side of the hospital's operation. While some members of the hospital staff would be full-time government employees, others might serve as consultants, on a part-time or sessional basis, or on a fee-for-service arrangement. Under this administration set-up, it should be possible for the private psychiatrist



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time government employees, others might serve as con-

sultants, on a part-time or seasonal basis, or on a

fee-for-service arrangement. Under this administration

set-up, it should be possible for the private psychiatric



1 to continue treating a patient after he has been admitted
2 to a provincial hospital, providing, in effect, a contin-
3 uity of treatment hitherto impossible.

4 5. While the existence of psychiatric units
5 in general hospitals and community mental health centres
6 will reduce the need for rehabilitation services by
7 helping the patient back to health in his community,
8 special consideration must still be given to this aspect
9 of the work, and arrangements must be made for full
10 rehabilitation of all discharged patients.

11 6. It is recommended that the present
12 limited out-patient mental health services for children
13 be expanded, and service on an in-patient basis be
14 established.

15 7. There is a need for considerable ex-
16 pansion in the program of services for the mentally
17 retarded.

18 8. Some provision should be made for the
19 supply of free medication to patients in need. This
20 might be done either through provisions of the Hospital
21 Services Act or the Public Assistance Act. Experience
22 has shown that many patients can be discharged from a
23 mental hospital at an earlier date if a continuing
24 supply of medication is made available as needed. This
25 is true also for patients undergoing treatment at a mental
26 health clinic. Medication for psychiatric illnesses is
27 costly, and places a financial burden on the patient
28 which he is frequently unable to maintain, resulting in
29 additional anxiety in trying to provide medication from
30 an already limited budget or going without the necessary

ity of treatment might be impossible.

in general hospitals and community mental health centers will reduce the need for rehabilitation services in helping the patient back to health in the community. special consideration must still be given to this aspect of the work, and arrangements must be made for the rehabilitation of all discharged patients.

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limited out-patient mental health services be expanded and service on an in-patient basis be established.

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1 medication.

2 9. The removal of geriatric and mentally
3 defective patients from the provincial hospitals should
4 do much to relieve the appalling overcrowding in these
5 institutions. At the same time, it would enable the
6 professional staff to provide more adequate care for the
7 remaining patient population, which would consist largely
8 of chronic mentally ill people. We feel, however, that
9 in New Brunswick there would still be a serious staff
10 shortage, and we recommend that the following steps be
11 taken to alleviate this shortage:

12 (a) That a revision of salary scales be under-
13 taken to provide attractive salaries for
14 the various professions needed in caring
15 for the mentally ill, as well as for the
16 housekeeping staff necessary to carry out
17 other duties.

18 (b) That the standards in existing provincial
19 hospitals be raised to such a level that
20 they can be used again as training insti-
21 tutions, thus enabling them to provide a
22 continuing supply of professional help.

23 10. Both mental hospitals in New Brunswick
24 are below the standards set by the various accrediting
25 organizations, and it is essential that steps be taken,
26 both financial and otherwise, to bring these hospitals
27 into line with the accepted medical standards.

28 (Reference 2).

29 11. We urge that steps be taken immediately to
30 eliminate the discrimination which now exists against the



1 mental patient in the Hospital Insurance Act. As it
2 presently stands, the Act provides for the care of the
3 mentally ill patient while he is in a general hospital,
4 but does not provide for his care if he is in a provin-
5 cial mental hospital.

6 12. Since the human element is our great-
7 est natural resource, we urge the federal government to
8 provide a Research Fund in the field of Mental Health.
9 Such Research Fund should be adequate to the size of the
10 problem involved, and should at least equal funds being
11 spent for research in other fields by federal agencies.
12 While we realize that such research fund would have to
13 be under the control of federal authorities, we feel
14 strongly that its expenditure should be under the
15 direction of professional people, and that there should
16 be sufficient latitude to enable them to pursue all
17 promising leads in the prevention and treatment of mental
18 illness.. (Reference 3).

19 II

20 THE PROBLEM

21 13. An attempt to express the extent of
22 the problem of Mental Illness in terms of statistical
23 facts is extremely difficult. However, from a study of
24 National statistics concerning incidence and prevalence
25 of Mental Illness, i.e., annual admissions, discharges
26 and patient population of mental hospitals, psychiatric
27 units and special institutions, some pattern does emerge:

- 28 (a) The number of patients in mental hospitals
29 and institutions at any one time represents
30 nearly one-half of all the patients in all



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presently stands, the Act provides for the care of the mentally ill patient while he is in a general hospital, but does not provide for his care if he is in a provin-

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units and special institutions, some pattern does emerge:

(a) The number of patients in mental hospitals



1 hospitals in the country. (Reference 4).

2 (b) Admissions to mental institutions have
3 shown a significant increase in recent
4 years. (See Table I attached).

5 15. Table I shows this increase amounting
6 to more than 34%. However, during the same period, the
7 annual increase in the number of patients in residence
8 has been much slower, and when related to the total
9 population, has shown a decline. It would seem, then,
10 that the mental hospitals have gradually become more
11 active as treatment centres, admitting annually larger
12 numbers of patients for treatment, and discharging a
13 similarly larger number of patients each year.

14 15. In New Brunswick, it would appear,
15 then, that we are slowly swinging from the traditional
16 use of mental hospitals as custodial institutions.
17 Nevertheless, the problem presented by the chronic
18 mentally ill remains, and our offer of little more than
19 custodial care is a challenge to present knowledge of
20 treatment and to the apathy of governments and taxpayers.
21 An indication of this apathy is the cost of operating
22 these hospitals. While there has been some increase in
23 per diem cost through the years, it is worth noting that
24 the per diem cost per patient in 1959 was only \$4.58,
25 whereas the daily cost per patient in general hospitals
26 was in the region of \$18.00.

27 16. The presence of a large number of
28 geriatrics and mental defectives in mental hospitals
29 clouds and confuses a true appraisal of the extent and
30 cost of active treatment for the mentally ill.



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1 Approximately one-third of the beds in the Lancaster
2 mental hospital are occupied by geriatric and mental
3 defective patients for whom no active treatment is in-
4 dicated.

5 17. Again, statistics indicate only some
6 of the known facts of the problem, and do not show the
7 extent of minor mental and emotional disorders which
8 result in reduced working efficiency, industrial and
9 school absenteeism, marital discord, social dependency,
10 etc.

11 18. Figures from current studies carried
12 out in Canada and United States communities commonly
13 indicate that more than one-third of the adult population
14 have had definite psychiatric illness causing at least
15 temporary disability during their lifetime. (Reference 5).
16 In recent years, we have repeatedly used the statement
17 that at any one time, one person in ten is sufficiently
18 mentally ill to require professional help, preferably
19 from a medical doctor trained in psychiatry. Those with
20 minor emotional problems may receive professional help
21 from non-medical people working in the welfare, counsell-
22 ing and casework field.

23 19. The total cost of mental illness to
24 Canada and any of its provinces can only be estimated.
25 This cost extends far beyond the immediate operating
26 cost of our mental institutions, and must include the cost
27 of the services provided privately by psychiatrists,
28 family doctors who treat patients with mental illness,
29 the cost of providing helping services by the non-medical
30 professionals already referred to, and must also include



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1 the cost to the country of lost time, lost production
2 and the cost of supporting families during the loss of
3 the wage earner. It has been estimated that the cost of
4 mental disability to Canada and its citizens must
5 approach three-quarters of a billion dollars annually.
6 (Reference 6).

7 8 ATTITUDES TOWARD MENTAL ILLNESS

9 20. In spite of efforts that have been
10 made through the years by the Canadian Mental Health
11 Association and others to promote the concept of mental
12 illness, "as an illness", rather than a weakness in
13 character, the stigma associated with being mental has
14 persisted. While many people pay lip service to the
15 statement that mental illness is just like any other
16 illness, the truth is that even relatives and close friends
17 have difficulty relating to the mentally ill patient and
18 feeling comfortable about him as they used to. Isolation
19 in a mental hospital, being disregarded and forgotten by
20 relatives and friends indicate the true feeling of the
21 great majority of the general public toward the mentally
22 ill patient.

23 21. Compared to the rapid and striking
24 advances which have been made in the control of contagious
25 diseases and public acceptance of these diseases, mental
26 illness is lagging far behind. It would appear the
27 interest and energy of medicine has largely been directed
28 elsewhere, and only recently has the practice of psychiatry
29 been given its proper status in the medical profession.
30

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been given the proper status in the medical profession.



1 TREATMENT SERVICES

2 22. Treatment services in Canada to date
3 have, for the most part, been the major responsibility
4 of provincial governments, with financial assistance
5 from federal funds. Up until five years ago, only one
6 mental hospital in New Brunswick, located in Lancaster,
7 St. John County, served the entire provincial population
8 of 540,000. The opening of a second hospital in
9 Campbellton relieved somewhat the patient load on the
10 existing hospital at Lancaster, and brought the hospital
11 closer to home for patients from the north of the
12 Province.

13 23. Four Mental Health Clinics have been
14 opened in the Province since 1950. These are located in
15 Saint John, Moncton, Fredericton and Edmundston; but
16 services to the community from these clinics have been
17 somewhat sporadic and lacking in continuity, due to
18 changes in professional staff, particularly in the field
19 of psychiatry.

20 24. Recently Psychiatric Units in the
21 general hospitals at Saint John and Moncton have been
22 established, making a most valuable contribution to the
23 mental health treatment services. In the past, many
24 patients who could have been helped by psychiatric treat-
25 ment in a hospital setting have refused to accept treat-
26 ment because of the isolation and stigma. In many cases,
27 only when illness becomes extreme and deep-seated is
28 action taken, sometimes legal, to place the patient in
29 the nearest mental hospital for treatment. The provision
30 of better community mental health services will minimize



1 this problem.

2 25. Up to this time, hospitalization,
3 frequently of long-term duration, has been the chief
4 method of treatment for the majority of mentally ill
5 patients in this Province. This practice is in contra-
6 diction to the well-accepted tenet that hospitalization
7 should be but a phase in the total care of the patient,
8 and must be related to pre-admission and post-discharge
9 services. Only in recent years have a small number of
10 patients been privileged to receive treatment outside of
11 the hospital from the handful of psychiatrists in
12 private practice or from one of the mental health clinics.

13 26. Up to the present time, only a very
14 limited service has been available in the mental health
15 and mental illness field for children. This limited
16 service is provided on an out-patient basis by the mental
17 health clinics, but is severely hampered by the factors
18 relating to the operation of mental health clinics as
19 outlined above. The only in-patient service provided
20 for children in this province is admission to the pro-
21 vincial mental hospitals in Campbellton and Lancaster;
22 hence admission is primarily limited to those children
23 requiring infirmary or custodial care.

24 27. As far back as 1918, when the
25 Canadian Mental Health Association was founded, its
26 reports, resulting from surveys across the country,
27 stressed the importance of developing decentralized services,
28 particularly community mental health clinics, psychiatric
29 units in general hospitals, and even small regionally
30 based hospitals. The lack of psychiatric and psychological



1 services to serve our school systems, jails, courts, etc.,
2 is apparent.

3
4 REHABILITATION

5 28. Relatively speaking, very little in
6 the way of rehabilitation services can be offered to the
7 mentally ill patient. Staff shortages, isolation of
8 treatment services, lack of integration, community
9 attitudes - all these and more can be given as reasons
10 for the almost total lack of rehabilitation services in
11 this province.

12
13 RESEARCH

14 29. Reference has been made to the fact
15 that treatment of mental illness in Canada has lagged
16 behind other fields of medicine. When one looks at the
17 huge sums of money presently being spent on Research into
18 physical illnesses, and then compares these amounts to
19 the total being spent on Research into mental illness,
20 one of the answers to this lagging behind becomes self-
21 evident. This is a serious weakness in the mental
22 health program of our country, for progress in the treat-
23 ment program must come from Research findings and develop-
24 ments.

25 30. In 1952, Canada spent about \$400,000.
26 on Research into mental illness, or approximately three
27 cents per capita. In 1961, Canadian funds for mental
28 health research had just about doubled, amounting to
29 between \$800,000. and \$900,000. Allowing for the popu-
30 lation increase, this has meant an advance of from three



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30. In 1982, Canada spent about \$400,000.

on research into mental illness, or approximately three cents per capita. In 1961, Canadian funds for mental health research had just about doubled, amounting to



1 cents per capita to five cents per capita, per year.

2 31. In Canada, about the only sizeable
3 private fund for mental health research is that estab-
4 lished by the Canadian Mental Health Association.

5 During the last three years, approximately \$25,000. per
6 year has been collected publicly for our National Mental
7 Health Research Fund. A few thousand more has been
8 made available for local research projects through some
9 of the provincial divisions of the Association. Each
10 year, the total amount available in the National Mental
11 Health Research Fund is earmarked for the support of a
12 single researcher who is thereby given assured financial
13 backing for a period of three or four years.

14 32. This policy was established only
15 after careful and critical review of the policies in
16 effect governing the allocation of federal funds through
17 Federal Mental Health grants for Research. This permits
18 "career research", rather than short-term specific
19 project research. (Reference 3).

20 III

21 NEW PATTERNS OF TREATMENT AND FACILITIES

22 33. The practice of Psychiatry and the
23 care of the mentally ill has slowly been changing.
24 Emerging is a shift from isolation, segregation and
25 control to integration and community treatment services.
26 New Brunswick has just made a start in this direction.
27 Much remains to be done.

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29 MEDICAL INTEGRATION

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NEW PATTERNS OF TREATMENT AND FACILITIES

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Much remains to be done.



1 mental patient and the separation of mental hospitals
2 from other medical facilities has tended to emphasize
3 the attitude that the mental patient is not a medical
4 patient, but is somehow different. In New Brunswick,
5 this attitude is just beginning to change, and psychiatry
6 is being accepted as a medical specialty. The standard
7 of care is being raised, and the social stigma is being
8 reduced. Early recognition by the family doctor, hence
9 early treatment in the local community and continuity of
10 treatment during rehabilitation is enhanced. This
11 becomes possible with the integration of all health
12 services.

14 COMMUNITY DEVELOPMENT

15 35. With decentralization and establish-
16 ment of community treatment services, the community is
17 brought closer to the existing problems and its respon-
18 sibility, thus bringing about greater community interest
19 and involvement, not only in mental health services, but
20 in all health services.

22 FINANCING

23 36. The Hospital Insurance and Diagnostic
24 Services Act of 1957 provided assistance from federal
25 funds for all provinces wishing to institute a Hospital
26 Services Program. However, the Act specifically excluded
27 mental hospitals, and therefore discriminated most un-
28 fairly against mentally ill persons as compared with
29 physically ill persons, with one exception, those persons
30 suffering from Tuberculosis. While establishing the



1 psychiatric unit of the general hospital as acceptable
2 under the Act, they established the provincial hospital
3 as unacceptable under the Act. (Reference 7). This
4 exclusion had other far-reaching implications in that it
5 made mental illness and mental hospitals less acceptable
6 to the general public, and also excluded the possibility
7 of mental hospitals improving their facilities and staff
8 so that the treatment program could be brought to a
9 standard of effectiveness as compared to the hospital
10 treatment offered for physical illness.

11 37. This same discrimination exists in
12 prepaid medical care and medical insurance programs.
13 However, in certain instances a limited amount of service
14 is available under some of these insurance plans.
15 (Reference 8). Where early treatment facilities are
16 available, the best in treatment results follow.

17 38. At the present time, those who can
18 afford it may receive the best treatment from private
19 psychiatrists either in Saint John, Moncton, or elsewhere
20 outside the Province. Those who cannot afford such
21 services may be assessed at a mental health clinic, and
22 may receive limited treatment, if the clinic is fully
23 staffed. However, the numbers of patients in active
24 treatment at the clinics is very small in relation to
25 the total need. The patient seen and assessed by a mental
26 health clinic may require hospitalization. Except in
27 Saint John and Moncton, where psychiatric units are
28 located in the general hospitals, such a patient would
29 be referred to one of the provincial hospitals. Frequently,
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39. Saint John and Moncton, where psychiatric units are

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because the hospital is so far from home and so isolated,



1 the patient will not voluntarily enter these hospitals.
2 Such patients may become progressively worse until
3 community pressures require their committal to the pro-
4 vincial hospital, long after the time has passed when
5 psychiatric treatment would have been most effective.
6 Patients who are admitted or committed to the provincial
7 hospital at the present time have little hope of receiv-
8 ing active treatment because of serious staff shortages.
9 (See Table II attached).

10
11 PREVENTION

12 39. A number of professionals are working
13 in the field of keeping people mentally well. Working
14 in this area is the family doctor, the clergyman, the
15 school teacher, group leaders, youth leaders, and so on.
16 Industries who work toward achieving good working con-
17 ditions and high morale among their employees also work
18 toward prevention. School counsellors who help young
19 people understand and work at their best potential also
20 work toward prevention. The efforts of people working
21 in the field of prevention are uncoordinated and sporadic.
22 Little evidence is yet available to indicate the effect-
23 iveness of these efforts. Although the Canadian Mental
24 Health Association has as one of its major objectives
25 the promotion of good mental health and the prevention of
26 mental illness, it has little scientific basis upon which
27 to work.

28
29
30



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TABLE I

PATIENTS IN MENTAL HOSPITALS*

YEAR	1955	1956	1957	1958	1959
All admissions	32,222 (1,020)	36,438 (992)	37,672 (1,107)	40,296 (1,393)	43,184 (1,508)
First Admissions	21,774 (752)	25,097 (730)	25,582 (777)	26,536 (880)	28,066 (1,018)
Rate per 100,000 population	139 (137.5)	156 (131.6)	155 (137.5)	156 (152.5)	161 (172.5)
Re-admissions	10,448 (268)	11,361 (262)	12,090 (330)	13,760 (423)	15,118 (490)
Discharges	26,058 (747)	30,974 (831)	31,836 (938)	35,481 (1,062)	37,058 (1,362)
Resident patients at year end	63,683 (1,847)	65,107 (1,828)	65,768 (1,826)	66,213 (1,850)	66,433 (1,833)
Ratio per 100,000 population	406.4 (337.7)	405.7 (329.6)	397.2 (323.2)	389.4 (320.6)	381.6 (310.7)
Bed Capacity	57,009 (1,150)	58,014 (1,151)	57,193 (1,161)	59,904 (1,342)	61,983 (1,368)
Percentage of occupancy	114 (158)	114 (159)	116 (158)	114 (139)	109 (136)
Per patient per diem cost:					
Canada	2.97	3.34	3.70	4.08	5.31
Lancaster	2.48	2.58	2.94	3.47	3.91
Campbellton	6.45	5.80	6.71	6.43	5.26

Charges to Patients

\$20.00 admission fee.
\$1.50 or \$2.00 per day, depending on
ability to pay.
If patient is unable to pay, muni-
cipality is charged at rate
of \$2.00 per week.

* From D.B.S. Catalogue #83-204 - 1959.

() New Brunswick.



TABLE II

PERSONNEL RATIOS - NEW BRUNSWICK MENTAL HOSPITALS

STAFF IN ATTENDANCE FULL TIME	RECOMMENDED RATIOS AS PER A.P.A. STANDARDS		ACTUAL N.B. RATIOS
	Active Treatment Sections	Continuous Treatment Sections	All Treatment Mental Hospitals New Brunswick*
PHYSICIANS	1:30	1:50	1:92
PSYCHOLOGISTS	1:100	1:500	1:324
REGISTERED NURSES	1:5	1:40	1:56
SOCIAL WORKERS	1:80	New Admissions	1:160
ATTENDANTS	1:4	1:6	1:5.5

* Includes administrative staff.

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BENNETT, Hargrave & Engle; Chapter 3, page 41.
- 2) American Psychiatric Association Medical In-
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- 3) A New Fund for Research Careers in Mental
Health: Canadian Mental Health Association.
Copies available on demand.
- 4) Mental Illness in Canada - A display prepared
by the Canadian Mental Health Association
(Vancouver Branch) and the Department of

11 AUG 64

* Includes administrative staff.



Psychiatry, University of British Columbia, 1961.

5) Leighton, D.C.: The Distribution of Psychiatric

Symptoms in a Small Town, American Journal of

Psychiatry, Vol 112, No. 9, March 1956, 716-723.

6) Dr. William Mitchell: Editorial, Canadian

Psychiatric Association Journal, August 1961.

7) Brief: Presented by the Canadian Mental Health

Association to the Prime Minister and Members

of the Cabinet, December 2, 1960. Copies

available from the Association on demand.

8) Griffin, J.D.: Report on Hospital and Medical

Insurance Plans. Canadian Psychiatric

Association Journal, Vol. 5, No. 4, October

1960. 234-237.

CANADIAN MENTAL HEALTH ASSOCIATION

NEW BRUNSWICK DIVISION,

4 HAZEN AVENUE

P.O. BOX 464

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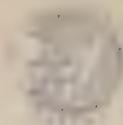
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Dr. J. C. Bourque, Psychiatrist, Edmundston, N.B.



CANADIAN MENTAL HEALTH ASSOCIATION

NEW BRUNSWICK DIVISION

STAFF OF THE DIVISION

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Dr. R. R. Prosser, Psychiatrist, Moncton, N.B.

Mr. Gerard Cormier, Psychologist, Moncton, N.B.

Mr. Ronald Lavoie, Social Worker, Moncton, N.B.

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Mr. John Murphy, Psychiatrist, Lunenburg, N.B.

Mr. J. A. Bishop, Psychiatrist, Moncton, N.B.

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Mr. J. A. Bishop, Psychiatrist, Moncton, N.B.

Dept. of Health, Fredericton, N.B.

Murray Manser, Social Worker, Fredericton, N.B.

J. C. Bourque, Psychiatrist, Edmundston, N.B.



1 THE CHAIRMAN: There is an item

2 here in paragraph 4, page 2 that I would like to have your
3 views on; it arises out of that. You are recommending
4 that the provincial hospitals be changed over so as to
5 resemble more closely the general hospitals?

6 MR. CRAIG: Yes.

7 THE CHAIRMAN: We have heard, and
8 I think it is perhaps generally accepted, that the best
9 place for the mental patient is in the general hospital
10 by and large: Now, is it implicit in this recommendation
11 for New Brunswick that you continue these provincial
12 hospitals, or is this merely bowing to the necessities
13 of the day and carrying on with them?

14 MR. CUSHING: We feel it is inevit-
15 able that there will be some long term patients for quite
16 a long time yet who must be cared for. These patients
17 must be looked after, and that to provide better care
18 for them and better administration for the hospitals
19 while they are being looked after that a change should
20 take place in the administration.

21 THE CHAIRMAN: So you would gradually
22 move from what you might call a mental hospital to a
23 general hospital?

24 MR. CUSHING: Yes, we think it will
25 be a long time before we can get rid of these big in-
26 stitutions. We can't see how the existing population
27 can be moved out of the big provincial hospitals over-
28 night. We think they will be there for twenty-five or
29 thirty years yet. Meanwhile we hope new admissions can
30 be chiefly looked after in the psychiatric units of

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be chiefly looked after in the psychiatric units of



1 general hospitals. This is the trend and it seems to me
2 a tremendous improvement. For example, statistics in the
3 Saint John area indicate that with 2 per cent of the
4 beds that are in the provincial hospital in the Saint John
5 area, they are taking care of 25 per cent of the number
6 of patients -- 2 per cent of the beds, they look after
7 25 per cent of the patients.

8 THE CHAIRMAN: Well, thank you,
9 gentlemen. I would not want you to get the impression
10 because we have not pursued many questions that this is
11 not regarded as a subject of very profound interest to
12 this Commission. We have the opportunity of being able
13 to explore the field by way of questions and informations
14 in the other provinces. We have your brief and it will
15 be studied by our research people, and such further
16 information as we may require, any explanations that they
17 think are necessary, we will submit them to you in the
18 expectation you will be willing to give us that further
19 information.

20 MR. CUSHING: Thank you very much,
21 gentlemen.

22 THE CHAIRMAN: Then, we have the
23 submission of the New Brunswick Association for Retarded
24 Children.

25 --- EXHIBIT NO. 46: Submission of the
26 New Brunswick Associ-
27 ation of Retarded
28 Children.
29
30



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EXHIBIT NO. 46.

1
2 SUBMISSION

3 of

4 THE NEW BRUNSWICK ASSOCIATION FOR RETARDED CHILDREN

5
6 APPEARANCES:

7 Mrs. A. B. Connell

8 THE CHAIRMAN: Are you alone, Mrs.

9 Connell?

10 MRS. CONNELL: Yes. I am sorry; I
11 did expect our executive secretary to be here. She helped
12 prepare the brief and knows it much better than I do.

13 THE CHAIRMAN: How do you wish to
14 deal with this, Mrs. Connell?

15 MRS. CONNELL: Well, perhaps it
16 could be accepted as read, Mr. Chairman.

17 THE CHAIRMAN: We would be quite
18 pleased to do that.

19 MRS. CONNELL:

20 Preamble

21 1. The New Brunswick Association for
22 Retarded Children being a Division of the Canadian
23 Association for Retarded Children, and consisting of ten
24 local Branches in New Brunswick with approximately three
25 hundred members, wish to set forth what we, in accordance
26 with the Canadian Association for Retarded Children,
27 who have set forth in their Brief to the Royal
28 Commission general information regarding Mental Retarda-
29 tion, consider relevant facts concerning our work. These
30



1942

PROCEEDINGS OF THE

THE CANADIAN ASSOCIATION FOR RETARDED CHILDREN

Minutes

January 10, 1942

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1. The new Brunswick Association for

Retarded Children being a Division of the Canadian Association for Retarded Children, and consisting of ten local Branches in New Brunswick with approximately three hundred members, wish to set forth what we, in accordance with the Canadian Association for Retarded Children,

who have set forth in their Report to the Royal

Commission on Mental Subnormality (1939) have done, consider relevant facts concerning our work. These



1 facts with recommendations appertain acutely to our work
2 and the development of the same. We therefore deem it
3 important to bring these facts and recommendations to
4 the attention of the Royal Commission on Health Services
5 at this time:

6 2. We should point out that although
7 we have made a considerable number of recommendations in
8 this Brief, all of which relate to non-existing or in-
9 sufficient programmes for the Mentally Retarded in New
10 Brunswick, we do recognize and fully appreciate the
11 remarkable work presently being done by many individuals,
12 and Departments of Government.

13 3. In 1959, for instance, there
14 were only four classes for the Trainable Mentally
15 Retarded in this Province. There are now twelve such
16 classes with more being contemplated in the near future.

17 This does not represent solely the
18 help given to the Children attending the Classes. It
19 represents much work and effort on the part of the Parents
20 of these Children, and their fellow citizens, both in
21 the professional disciplines and amongst the lay public.
22 It represents a tremendous awakening of public awareness
23 of our responsibilities to our Retarded Children.

24 4. The growing knowledge that Mental
25 Retardation is a complex, and often baffling condition,
26 and that many types of programmes are necessary to
27 promote the best development of the individual, has
28 added stimulus to the efforts of all those immediately
29 concerned with this problem.

30 5. We consider ourselves fortunate in



...the attention of the Royal Commission on Health Services

at this time:

2. We should point out that although we have made a considerable number of recommendations in this Bill, all of which relate to non-existing or insufficient programmes for the Mentally Retarded in New Brunswick, we do nevertheless and fully appreciate the remarkable work presently being done by many individuals and departments of Government.

3. In 1959, for instance, there were only four classes for the Terminally Mentally Retarded in this Province. There are now twelve such classes with more being contemplated in the near future. This does not represent solely the

help given to the Children attending the Classes. It represents much work and effort on the part of the Parents of these Children, and their fellow citizens, both in the professional disciplines and amongst the lay public. It represents a tremendous awakening of public awareness of our responsibilities to our retarded Children.

4. The growing knowledge that Mental Retardation is a complex, and often baffling condition, and that many types of programmes are necessary to promote the best development of the individual, has concerned with this problem.

We consider ourselves fortunate in



1 New Brunswick that we, who are most closely involved
2 with this work have the whole-hearted co-operation of
3 various Departments of the Provincial Government, the
4 Medical profession, the Victorian Order of Nurses, the
5 Children Aid Societies, the Public School authorities
6 and teachers in the Public Schools. The development of
7 our work is greatly advanced because we are able to
8 enjoy this close relationship with all the allied Health
9 and Educational Services.

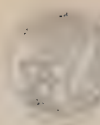
10 6. The needs of our Mentally Retarded
11 are many and various. In New Brunswick our chronically
12 disabled Mentally Retarded number approximately fifteen
13 thousand, trainable Mentally Retarded four thousand,
14 and completely Dependent six hundred.

15 7. The need for more and better
16 facilities and programmes is evident and urgent. The
17 need for further financial aid is evident and urgent.
18 The need to encourage more people to become trained to
19 develop the various programmes satisfactorily is urgent.

20 8. But we feel the most urgent need of
21 all is, on a National scale, competent Research into
22 the Etiology and therefore it is to be hoped, the
23 prevention of a condition which cripples to a greater
24 or lesser degree no less than three per cent of our
25 population.

26 Facts Relating To Our Work:

27 9. There is a serious shortage of
28 Psychiatric Community Clinics, or Mental Health Clinics
29 in New Brunswick at the present time. There are only
30



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 ...the Victorian Order of Nurses, the
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 or lesser degree no less than three per cent of our
 population.

Tasks Relating To Our Work:

9. There is a serious shortage of
 in New Brunswick at the present time. There are only



1 four such Clinics, and these four are not fully staffed.
2 It is obviously impossible that four Mental Health
3 Clinics, even if they were fully staffed could approach
4 being able to cover the Mental Health needs of the
5 people of this Province satisfactorily.

6 10. To date the Mental Health Clinical
7 Services have had to be restricted to a great extent to
8 Diagnosis, owing to the tremendous case load the
9 professional staff have had to carry. Very little
10 treatment, as such, has been able to be carried out
11 owing to the pressure of the number and variety of cases
12 needing attention. Albeit, the professional help and
13 guidance given by the Mental Health Clinics in this
14 Province has been outstanding.

15 11. The present Mental Health Clinics
16 are located in Saint John, Moncton, Fredericton, and
17 Edmundston. There are therefore many areas of the
18 Province where the lack of Mental Health Clinical Service
19 is keenly felt.

20 12. In New Brunswick there is no Resi-
21 dential Hospital Training School or Residential Treatment
22 Centre for Mentally Retarded Children.

23 13. This is a matter of very grave concern
24 to a large number of the people of the Province. It is
25 only too obvious that the need for Residential facilities,
26 with both In-Patient and Out-Patient care is of primary
27 importance and most urgent.

28 14. At present a very small number of
29 Mentally Retarded Children are being cared for by our
30 two Provincial Mental Hospitals; this number being



1 approximately sixty (60) children, or approximately
2 thirty (30) children in each Provincial Mental Hospital.
3 Short-stay care is also provided by the two Provincial
4 Mental Hospitals; this care lasting not more than sixty
5 (60) days, and dependent upon whether space is available.

6 15. Since the Provincial Mental Hospitals
7 were never intended to fill the function of Hospital
8 Training Schools for Mentally Retarded Children, the
9 only programmes provided for the Mentally Retarded
10 children being cared for is of a very sketchy nature.

11 16. However, under the circumstances
12 which are indeed to be deplored, the Provincial Mental
13 Hospitals must be thanked and congratulated for the
14 truly humanitarian attitude they have adopted in caring
15 for some acute and needy cases of Mentally Retarded
16 Children who have been admitted for Custodial care, or
17 short-stay observation.

18 17. Conditions for the Mentally Retarded
19 Children in the Provincial Mental Hospitals are in no
20 way ideal, but considering the intense pressure on the
21 Hospitals for accommodation for the Mentally ill, for
22 whose care and treatment the Hospitals are entirely
23 geared and staffed, we realize the additional difficulties
24 encountered by all the professional staff in caring for
25 the Mentally Retarded Children.

26 18. It is our most urgent desire that
27 this unfortunate and deplorable situation will be recti-
28 fied as soon as is humanly possible, and that Hospital
29 Training Schools for the Mentally Retarded, and Treatment
30 Centres, will be in operation in the near future.



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1 19. Further to the dire need for Residen-
2 tial hospital Training School and Treatment Centres for
3 the Mentally Retarded, is the need for other special
4 Community facilities for the Training of the Mentally
5 Retarded.

6 20. At present the only programmes for
7 the Trainable Mentally Retarded are the Day Training
8 Classes and recreational programmes organized by the
9 local Branches of the New Brunswick Association for
10 Retarded Children, or other such organizations. There
11 are approximately 165 children being accommodated in
12 these programmes. Good as are these programmes, there
13 is a growing and ever more pressing need for more such
14 classes and other facilities.

15 21. Possibly almost more important is
16 the really serious shortage of Special Educational
17 facilities for the Mildly Retarded, or Slow Learner.

18 22. These latter classes are, admittedly,
19 the concern of the Public School System, but the Mental
20 Health and development of the individual is a matter of
21 concern to our Association.

22 23. Since the number of Educable Mentally
23 Retarded in this Province is nearly four times that of
24 the Trainable Mentally Retarded it is a matter of con-
25 siderable concern to us that so little is being done in
26 the Educational field for this large group of Children.
27 Their needs are very real, and we feel that the Public
28 School Authorities in New Brunswick have a very serious
29 responsibility to these Children in providing proper and
30 suitable programmes to meet their particular needs.



1 24. Beyond the very meagre Training
2 facilities for the Trainable Mentally Retarded already
3 mentioned, we have little or nothing to offer these
4 Children.

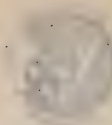
5 25. There are a few such children in
6 Foster Homes in the Province. These Homes are private
7 Homes which have been duly approved and licensed by
8 Provincial Government Authorities, for the particular
9 function they fulfil. A financial grant can be made to
10 the guardians of these Mentally Retarded Children while
11 they are in the care to the Foster Home.

12 26. However it must be plain to even the
13 most casual observer that many more and diverse programmes
14 are badly needed.

15 27. In referring to the Mentally Retarded
16 Child we tend to overlook the fact that these Children
17 may also be Emotionally Disturbed, since they are not
18 immune to the stresses and emotional upsets of their
19 social environment.

20 28. Special Services to cope with this
21 particular aspect of the Mental Health Programme are
22 very important.

23 29. At the present time, the already
24 very busy Mental Health Clinics in the Province are
25 giving an excellent service whenever and wherever possible.
26 This is most valuable service, but the shortage of both
27 Clinics and professional personnel in the Clinics, means
28 that only very few of the Mentally Retarded Children
29 with Emotional Disturbance as a co-existing condition
30 are able to get the special help they need.



There are a few small children in

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Clinics and professional personnel in the Clinics, means

that only very few of the Mentally Retarded Children

with Emotional Disturbance as a co-existing condition

are able to get the special help they need.



30. A child Guidance Service which will be specially directed to help the Emotionally Disturbed and the Mentally Retarded, is being set up in Saint John, but this is a very recent development, and not in operation.

PART TWO

Recommendations:

31. Since the shortage of Mental Health Clinics in the Province is really serious, we recommend that immediate consideration be given to increasing both the number and the scope of such Clinics. The areas in the Province where we consider Clinics should be set up are:

(a) the Newcastle-Chatham area.

(b) Bathurst.

(c) Campbellton.

(d) Woodstock.

(e) St. Stephen

37. All of these clinics may not require a full-time Clinical Staff, which is comprised of a Psychiatrist, Psychologist, Psychiatric Social Work and clerical Staff, but should be served at least a full-time or part-time Clinic.

38. There should be also a Child Guidance Clinic operation in conjunction with the Mental Health Clinic.

39. We all recommend that the Mental Health Clinic Staff be strengthened by the addition of specially-trained personnel in the field of Mental



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32. (a) the Newmarket-Oakton area.

33. (b) Belmar.

35. (d) Woodstock.

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a full-time Clinical Staff, which is composed of a
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38. There should be also a Child Guidance

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39. We all recommend that the Mental

Health Clinic Staff be strengthened by the addition of

specialized personnel in the field of Mental



1 Retardation, to be responsible for the development of
2 specific counselling and treatment programmes for the
3 Mentally Retarded.

4 40. The formation of Mobile Clinics.

5 41. The main purpose of the Mobile Clinic
6 would be to bring Mental Health Diagnostic Services to
7 areas in the Province where the population is not con-
8 centrated in any large centre.

9 42. It would seem that two or three such
10 Mobile Clinics would be sufficient, if at the same time
11 the number of permanent Clinics is increased.

12 43. The Mobile Mental Health Clinic would
13 not necessarily require the appointment of a Psychiatrist,
14 since those cases needing Psychiatric Assessment would
15 be referred to the nearest permanent Mental Health Clinic.

16 44. In order to maintain a Continuous
17 Mental Health Division, Department of Health in New
18 Brunswick, employ Mental Health workers.

19 45. These Mental Health workers would
20 not of necessity be Psychiatric Social Workers, but
21 rather persons suited by experience and training in the
22 particular field of Mental Retardation.

23 46. Their function would be:

24 47. (a) To act as liason between the Hospital
25 Training Schools Mental Health Clinics,
26 Day Training Classes and Special Classes,
27 and the Home and Community.

28 48. (b) To act as Counselors and helpers to the
29 Parents of Mentally Retarded Children. This
30 service to be brought specifically into the

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1 Home invironment.

2 49. (c) To undertake follow-up programmes when a
3 child or young person has been discharged
4 from Residential care, and requires dir-
5 ection and guidance.

6 50. (d) To maintain a close contact with all facil-
7 ities for the Mentally Retarded in their
8 local area, and be thoroughly capable of
9 interpreting the various Community
10 Services available, both to the individual
11 involved and to their Parents or Guardians.

12 51. The Mental Health Worker should be
13 an integral part of any Community Mental Health Programme.

14 52. Thus the Mental Health and care of
15 the Mentally Retarded person in their own home would be
16 greatly advanced.

17 53. As has been stated, the present
18 situation whereby there is no Residential Care for our
19 Mentally Retarded Children in New Brunswick, is a matter
20 for the gravest concern.

21 54. We recommend in the strongest terms,
22 that at the earliest possible time the Government of
23 New Brunswick build, and adequately staff, three Resi-
24 dential Training Schools and Treatment Centres for the
25 Mentally Retarded.

26 55. These Hospital Training Schools and
27 Treatment Centres should provide up-to-date In-Patient
28 and Out-Patient Care. They should be located in Saint
29 John, Moncton, and one in the Northern part of the
30 Province, in either Campbellton or Edmundston.



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1 56. The recommendation is voiced by the
2 New Brunswick Association for Retarded Children, but
3 speaks also for many thousands of the people of the
4 Province.

5 57. We recommend that where practicable,
6 i.e., in the larger centres of population, Community
7 Services for the Mentally retarded be given serious con-
8 sideration. These services should include the following:

9 58. (a) Day Care Centres for pre school age
10 Mentally retarded.

11 59. (b) Short-stay Residential Hostals for children
12 attending Day Training Classes or other
13 such programmes for the Mentally Retarded.
14 Specifically these Hostels would be for
15 children living too far away from such
16 classes or other programmes to otherwise
17 be able to attend them.

18 60. (c) Residential Hostels for the Adult Mentally
19 Retarded person who is attending Sheltered
20 Work Shops or other such programmes, which
21 would include the Mentally Retarded person
22 in regular employment. These Hostels should
23 also provide accommodation for Mentally
24 Retarded persons when such care cannot be
25 provided by the individual's own family.

26 61. (d) Rest Homes for Mothers of the Mentally
27 Retarded. These Rest Homes would provide
28 a short respite for the Mother whose own
29 health or well being was in danger owing to
30 the constant strain of caring for her



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1 Mentally Retarded Child.

2 62. (e) Training Programmes for the adult Mentally
3 Retarded person. Specifically these pro-
4 grammes should be geared to train the in-
5 dividual who has not had previous training,
6 in order to develop his potentialities to
7 the greatest degree of function for the
8 individual.

9 63. (f) Rehabilitation Services. These services
10 should be undertaken by persons qualified
11 in the field of Social Work or job placement
12 for the Mentally Retarded.

13 64. (g) Foster Home Care for the Mentally Retarded
14 Child, who for various reasons is not able
15 to be cared for by their own family.

16 65. (h) Increased programmes for the Educable
17 Mentally Retarded:

18 1. Special Educational programmes.

19 11. Occupational Training.

20 111. Recreational programmes.

21 1V. Job placement service.

22 66. All the above mentioned recommendations
23 regarding Community services for the Mentally Retarded
24 would require financial support from Provincial Government
25 funds, but should be financed also from Municipal funds
26 in the areas where any or such Community Services of the
27 nature outlined are undertaken.

28 67. Increased Research in the field of
29 Mental Retardation. There is ever-growing need for
30 Government financial support to those persons competent



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1 to carry on Research in any of the various aspects of
2 Mental Retardation. We therefore recommend that as the
3 professional services already suggested in this Brief,
4 develop New Brunswick, and as the number of professional
5 persons become involved, that encouragement and financial
6 support be made available to those persons wishing to
7 enter the Research aspects of this work.

8 68. Since many parents of Mentally Re-
9 tardated Children remain ignorant of the condition of their
10 child at any early age, owing to the lack of either
11 early diagnosis, or because they have not been told of
12 the existence of this condition regarding their child by
13 the attending Physician; we strongly recommend that the
14 condition of Mental Retardation be reported by the
15 Physician to the Parents, and also to the proper author-
16 ities, this being the District Medical Health Officer,
17 as is so in the case of infectious diseases.

18 69. We recommend that the training of
19 personnel in the care of the Mentally Retarded Child is
20 of the utmost importance. Especially this is so in
21 respect to those persons employed in the care of the
22 Mentally Retarded in Residential Hospital Training
23 Schools and Treatment Centres.

24 70. It appears that training facilities
25 for professional personnel in the care of Mentally Re-
26 tardated are very meagre. Where a Hospital Training School
27 or Treatment Centre is able to give special courses to
28 their professional staff, including teachers, it should
29 not be necessary for such training to be provided else-
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1 However, we recommend that serious consideration be
2 given to the setting up of Courses of Training for those
3 persons wishing to be employed in the teaching or care
4 of the Mentally Retarded.

5 71. It would appear possible that such
6 courses of training could be included in the programmes
7 for the training of Registered Nursing Assistants being
8 offered at the New Brunswick Technical School; The
9 Handicraft Division, Department of Industry and Develop-
10 ment; the Art Department of Mount Allison University and
11 elsewhere; the Music Departments of our Universities and
12 Colleges.

13 72. We recommend also, that consideration
14 be given to Social Work Training which would include job
15 Placement Service for those persons wishing to work in
16 this specific field with the Mentally Retarded.

17 73. It would seem foolhardy to contem-
18 plate the building and staffing of modern Hospital
19 Training Schools and Treatment Centres, and the setting
20 up of various other needed facilities, unless we are
21 prepared to employ properly qualified and trained staff
22 competent to carry out and develop the programme involved.
23 It would also appear quite possible to set up satisfactory
24 Courses of Training within the Province of New Brunswick.
25 Financial support in the way of grants and Bursaries
26 will doubtless be necessary to encourage personnel to
27 take the Courses provided. At the present time, proper
28 preparation for life for the Mentally Retarded is one of
29 our most pressing needs.

30 74. We recommend that under the direction

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We recommend that under the direction



1 of the District Medical Health Officer, all Public
2 Health Services be made available to Mentally Retarded
3 Children attending Day Training Classes, and that these
4 services are provided in the special school or class
5 room setting.

6 75. In New Brunswick at present, where
7 there is a class for the trainable Mentally Retarded,
8 Public Health Nursing Services are available for such
9 children as are attending the classes. However these
10 services are not always given to these children for
11 various reasons.

12 76. (a) In working out schedules of visits to
13 schools, these Day Training Classes tend
14 to be overlooked.

15 (b) In certain areas, some services such as
16 immunization of school children is performed
17 outside the school or class room in a
18 public clinic, such as a Child Health
19 Conference.

20 78. The Mentally Retarded child shows a
21 higher incidence of co-existing physical disabilities
22 than does the Public School population. These disabili-
23 ties tend to be neglected often owing to the difficulty
24 of getting the child to a public clinic. It is therefore
25 much easier or more convenient for the Mentally Retarded
26 Child to be examined in the special school or class room
27 setting.

28 79. We recommend also that benefits of
29 the Province of New Brunswick Hospital Service be extended
30 to cover dental treatment for the Mentally Retarded in



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1 the out-patient departments of our Hospitals when such
2 treatment is deemed necessary.

3 80. Extension of the age limit of the
4 Family Allowance for the Mentally Retarded.

5 81. Since the Mentally Retarded child is
6 entirely dependent upon his home and parents or guardian,
7 and since this condition is likely to continue into and
8 through adult life. We would strongly recommend that the
9 Family Allowance continue in the case of the Mentally Re-
10 tarded beyond the present terminal age of 16 years. We
11 would recommend that in the case of the Mentally Retarded
12 the age limit be extended to 18 years of age.

13 82. In respect to the Disability Pension
14 we would most strongly recommend that this pension be
15 available to Mentally Retarded persons of 18 years of
16 age and over who by dint of their condition are unable
17 to earn their own living or are only partially economically
18 independent. It is very evident that the adult Mentally
19 Retarded person who, because of the individual's condition
20 is unable to earn his or her living, or is only partially
21 economically independent, should be in receipt of some
22 financial support to enable the individual to be assured
23 of some financial support.

24 83. We would further recommend that since
25 the general public are to a very large extent ignorant of the
26 implications of Mental Retardation, and as it would seem
27 reasonable to inform the general public of such implication,
28 that a small pamphlet be written by a proper authority on
29 this subject, and that this pamphlet should be enclosed each
30 third or fourth month in the Family Allowance cheque.



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1 THE CHAIRMAN: Any comments you
2 would want to make, we would be glad to have.

3 MRS. CONNELL: The recommendations
4 in the brief as prepared I regret to say are far too
5 many and not too well organized. I think that the great-
6 est need, perhaps, is for more mental health clinics in
7 the province. We have approximately 15,000 mentally
8 retarded people in the province. That is not children.
9 Trainable mentally retarded number 4,000, and completely
10 dependent, 600. The trainable mentally retarded, that
11 our association is concerned with, we have great difficulty
12 in getting the children; of course, they are very much
13 less -- perhaps, 150 mentally retarded children now
14 attending schools in the province. There are ten or
15 twelve schools operated by branches of our association.
16 It is difficult for these children to get through mental
17 health clinics to be assessed so they can be sent to these
18 schools for further training.

19 THE CHAIRMAN: Is there any pre-
20 school assessment?

21 MRS. CONNELL: Well, unless the
22 parent takes her child to a clinic, there is no pre-
23 school assessment. Most of the children come to us through
24 the school when they are found inadequate in grades one
25 and two.

26 THE CHAIRMAN: How are they found
27 then -- by the teacher or the public health nurse?

28 MRS. CONNELL: Sometimes by the
29 teacher and sometimes by the public health nurse. In the
30 smaller communities the teacher would like to have help,

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1 but there is no clinic. The parent first takes the child
2 sixty, or eighty or a hundred miles to have the child
3 assessed, because every parent thinks their child is
4 perfectly normally mentally, and they don't like to accept
5 the fact these children should be in another school.
6 So, it is difficult not having people available to take
7 the child to. The Education Act with regard to these
8 special classes does not allow children to enter the
9 classroom unless they have been assessed by a psychologist.
10 We feel there is a great shortage of psychologists in
11 the province; a great need for more psychologists. There
12 is also need for guidance for the parents in the home.
13 We do not have that at the present time. Some children
14 are cared for in homes, and I am thinking of the home care
15 and the parent actually handling the child in the home.
16 There is real need there for help. Sometimes there is
17 need to find the child. A great many of the children are
18 not reported, and we don't know where they are. A public
19 health nurse asked me, "Why don't you make a survey?",
20 and I said, "Where would I go first?" I thought I would
21 go straight to the Department of Health. However, there
22 is a public nurse, herself, asking me to make a survey.
23 Our own division of mental health has made a very
24 excellent survey as far as they can go. We feel possibly
25 when a doctor finds a child is mentally retarded there
26 should be something similar to what there is in the case
27 of an infectious disease; a mentally retarded child
28 should be the same. There is going to be a need of social
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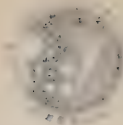
1 THE CHAIRMAN: But when they finally
2 get to the school age, it becomes ----

3 MRS. CONNELL: Yes, but every year
4 missed in these children's lives is like three years lost
5 in the normal child's life. If you just reach these
6 parents in time and assure them the place the child
7 should go is one of these schools, it would be a great
8 help. Then, of course, we have a great need for an
9 institution for retarded children. We had great hopes
10 there was going to be an institution in New Brunswick,
11 but it has not been built yet. The parents constant
12 concern is, "Supposing anything happens to us: What can
13 we do with the child?" There is no place in New Brunswick
14 except the provincial hospital. That is of great concern
15 to parents.

16 Those are much the recommendations
17 we have in this list; there are others but I think perhaps
18 those are the most important.

19 THE CHAIRMAN: What co-operation,
20 if I may put it that way, is there in the elementary
21 school system once a child is found to be retarded? They
22 fall into various categories; some may not be capable
23 of being educated or trained at all, but those who are
24 trainable?

25 MRS. CONNELL: Well, there are
26 75 per cent who are educable. In some of the schools,
27 especially in city schools, there are classes --
28 opportunity classes we call them -- where these children
29 are taken apart and given a special course of studies,
30 but that is only in a few centres. There used to be a



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but that is only in a few centres. There used to be a



1 good many more of these classes than there are now. That
2 is because the teachers are not trained. Then there is
3 the moderately retarded child. The proportion is 25
4 to 1, of the children being in the moderate group. They
5 are being taken care of as much as possible by our
6 association. We have ten branches of the association in
7 the province. There are two other schools being organ-
8 ized, but not through the association. They are in
9 scattered communities, but I am looking forward to the
10 time when everyone in regional schools will have a class
11 for the mentally retarded. We have a wonderful school
12 system in New Brunswick with regional schools covering
13 the province pretty well, and in each of these there are
14 five hundred or six hundred pupils. Surely, there will
15 be pupils in quantity to warrant establishing a class
16 for the children in that area -- that would be in a
17 district of ten miles around. That is something I have
18 in my own mind. It is not in our brief, but I think
19 the time will come when we will be covering the province
20 much better and getting the children to the schools.
21 Once in the schools we have the facilities of the public
22 health nurse and the Victorian Order of Nurses when they
23 are organized. They do attend the schools, but these
24 children we are talking of have another disability:
25 They often have poor physical health. Some of them are
26 epileptic.

27 THE CHAIRMAN: That is the area in
28 which this Commission is primarily concerned.

29 MRS. CONNELL: Yes, they really come
30 into the field of health, and provincially we feel our



Good many more of these classes than there are now. That is because the teachers are not trained. Then there is moderately retarded child. The proportion is 25 to 1, of the children being in the moderate group. They are being taken care of as much as possible by our association. We have ten branches of the association in the province. There are two other schools being organized, but not through the association. They are in scattered communities, but I am looking forward to the time when everyone in regional schools will have a class for the mentally retarded. We have a wonderful school system in New Brunswick with regional schools covering the province pretty well, and in each of these there are five hundred or six hundred pupils. Surely, there will be pupils in quantity to warrant establishing a class for the children in that area -- that would be in a district of ten miles around. That is something I have in my own mind. It is not in our budget, but I think the time will come when we will be covering the province much better and getting the children to the schools. Once in the schools we have the facilities of the public health nurse and the Victorian Order of Nurses when they are organized. They do attend the schools, but these children we are talking of have another disability: They often have poor physical health. Some of them are

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into the field of health, and provincially we feel our



1 effort is in the field of health.

2 THE CHAIRMAN: On the assumption
3 that there might be an over-all, what we have been calling,
4 comprehensive medical health service, where would such
5 an organization as yours fit into a programme of that kind?
6 What is to become of the voluntary organization if the
7 future brings into being a state operated comprehensive
8 health service?

9 MRS. CONNELL: I think there is
10 still need for voluntary services. There is for the
11 establishment of public opinion. We must have our
12 voluntary associations. However, I think the voluntary
13 associations will very gladly surrender their control of
14 the schools when the time comes for the department to
15 take over.

16 THE CHAIRMAN: But it would not mean
17 the disbandonment of the association?

18 MRS. CONNELL: No. Our associations
19 are not only made up of parents of retarded children, but
20 of other people interested in this field. I think you
21 will find there is a very large body of public opinion
22 working for the retarded child.

23 COMMISSIONER McCUTCHEON: You would
24 reserve your right to criticize the operation of the new
25 scheme?

26 MRS. CONNELL: Well, that is what
27 democracy is, isn't it?

28 THE CHAIRMAN: Thank you very much,
29 Mrs. Connell. You will accept our assurance that your
30 brief will be read with care and that the recommendations



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4
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28 brief will be read with care and that the recommendations



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Connell

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1 even though you say they may be too numerous, will be
2 looked at, and that this problem of the mentally retarded
3 child will have the serious consideration of the
4 Commission.

5 MRS. CONNELL: Thank you very much.

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Connell

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I have thoughtfully read your letter of the 28th inst. and
in reply to inform you that this portion of the contract is
being dealt with the same consideration as the other.

MRS. CONNELL: Thank you very much.



1 THE CHAIRMAN: Mr. Menzies?

2 I understand there is a person who wishes to make a
3 submission. Is there anyone else here who wishes to say
4 anything to the Commission while we are still in session?

5 Mr. Menzies, you have handed in a
6 document here which you wish filed and studied by the
7 Commission?

8 MR. MENZIES: Yes. I think it is
9 very kind of you to accept this, because I should have
10 had it in before, but I just wish you to consider this in
11 relation to our small enterprise.

12 THE CHAIRMAN: Well, the document
13 will be accepted and it will be Exhibit No. 47. Thank
14 you, Mr. Menzies, for appearing.

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THE CHAIRMAN: Well, the document

will be accepted and it will be Exhibit No. 47. Thank

you, Mr. Menzies, for appearing.

Submission of A. H. Menzies & Sons Limited

A. H. Menzies & Sons Limited is a private company doing business primarily in the Maritime Provinces and the adjoining area in the United States of America. The Company was recently incorporated to continue a business commenced and carried on by the Menzies family for more than forty years. The Company is vitally concerned with health services as it is the only Maritime manufacturer of artificial limbs and orthopedic braces and splints. The Company employs ten persons and operates completely without assistance from government sources at any level. The employees include a number of people who are amputees, three of whom are being trained on the job, a situation which normally qualified for Government Grants.

A. H. Menzies & Sons Limited supply their products to patients of Maritime hospitals, to patients receiving assistance under the Provincial Rehabilitation programme, to Women's Compensation Board cases, to the Government of Canada and to members of the general public in Eastern Canada and the United States.

Artificial limbs and other products are occasionally supplied on prescription from surgeons but the majority of sales are made directly to the persons involved, since for obvious reasons the trade has always involved intimate contact between the company and the patient. The type of appliances, the fittings and the training is, and always



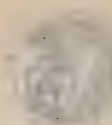
1 has been, regarded by the company as its responsibility.
2 The field is a very specialized one and in many areas
3 medical specialists with special knowledge of the physical
4 aids available from the industry, and the art of fitting
5 the same are non-existent.

6 The Company enjoys, at the present
7 time, very good relations with both Provincial and Federal
8 governments. This is especially evidenced by the referral
9 of Workmen's Compensation Board cases to it.

10 The Menzies Company adheres to the
11 policy of accepting return of their artificial limbs
12 (although made to measure in each case) if the purchaser
13 cannot learn to use them before leaving the Menzies
14 fitting rooms. This policy, accompanied by the highest
15 possible quality in production, has enabled the Company
16 to compete successfully up to the present time with lower
17 priced mass-produced products sold through the mail order
18 system or by peddlers. The practice of peddling artificial
19 limbs is gradually dying out.

20 While the management enjoys excellent
21 relations with members of the medical profession, it does
22 not favour any limitation on its present right of dealing
23 with individuals directly, as experience has shown over
24 the Company's many years of operation, that direct
25 communication between the patient and the manufacturer
26 makes for better satisfaction to both.

27 The Menzies Company is a member of
28 the Interprovincial Association of Prosthetists and
29 Orthotists of Canada and has attached hereto a copy of
30 the Association booklet for the information of the Royal



has been regarded by the company as its responsibility.
The company has been very successful in its operations.
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The Company enjoys, at the present
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Governments. This is especially evidenced by the referral
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The Membrane Company adheres to the
policy of accepting return of their artificial limbs
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the Company's many years of operation, that direct
communication between the patient and the manufacturer
makes for better satisfaction to both.

The Membrane Company is a member of
the International Association of Prosthetists and
Orthotists of Canada and has attached hereto a copy of



1 Commission.

2 All of which is respectfully submitted
3 this tenth day of November, in the year of our Lord one
4 thousand nine hundred and sixty-one.

5 THE CHAIRMAN: Is there anyone else
6 present who wishes to say anything? We had one or two
7 indications that some other briefs may come in.

8 THE SECRETARY: There are no other
9 briefs at this time.

10 THE CHAIRMAN: In any event, we have
11 taken care of all those who have indicated they would be
12 here?

13 THE SECRETARY: That is right, sir.

14 THE CHAIRMAN: So we have now arrived
15 at the end of our public hearings in Fredericton and for
16 the Province of New Brunswick.

17 Before closing I would like to express
18 on the behalf of the Commission the thanks of the
19 Commission for those who appeared. It was a very fruitful
20 session that we have had, and we appreciate the great
21 assistance that has been forthcoming from the eleven or
22 twelve organizations and individuals who have appeared.

23 This completes our hearings in the
24 Atlantic Provinces, and we will continue our hearings later
25 on in Western Canada and later in the Central Provinces.
26 So the hearing is now adjourned.

27 --- Hearing adjourned.
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30

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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

WINNIPEG

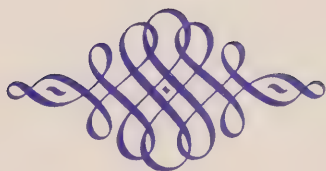
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VOLUME 12

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MANITOBA, ON BEHALF OF THE
GOVERNMENT OF MANITOBA 3072

THE FACULTY OF MEDICINE,
UNIVERSITY OF MANITOBA 3156

THE WELFARE COUNCIL OF GREATER
WINNIPEG 3175

THE VICTORIAN ORDER OF NURSES
FOR CANADA ON BEHALF OF ITS
BRANCHES IN MANITOBA 3192



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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Winnipeg, Manitoba,
15th day of January, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL -- Chairman
MISS ALICE GIRARD, R.N.
DR. DAVID M. BALTZAN
PROF. O.J. FIRESTONE
MR. M. WALLACE McCUTCHEON, Q.C.
DR. C.L. STRACHAN
DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MAJ. N. LAFRANCE

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DR. ARTHUR T. VAN WART

COMMISSION COUNSELL:

MR. R.N. HALL, O.C.

DIRECTOR OF RESEARCH:

SECRETARY:

Mrs. N. LAIRANCE



Winnipeg, Manitoba,
Monday, January 15th,
1962.

H/dpw

--- On commencing at 10 a.m.

THE CHAIRMAN: Mr. Premier, Mr. Johnson, ladies and gentlemen: we are embarking on the second phase of our public hearings here in Winnipeg; we completed our hearings in the Atlantic Provinces in November and now we are going to be in the four Western Provinces in the next month. We see that we have a considerable agenda of submissions to hear here in Winnipeg and we have tried to work out a tentative timetable which we may or may not be able to adhere to. I think we can put it this way, we want to hear from everyone who has a submission to make. We will try to give as much time as the submission appears to warrant so that everyone who has something worthwhile to offer may have an opportunity to do so. We will begin the proceedings this morning with the presentation from the Government of Manitoba.

Mr. Premier, I welcome you here this morning. Your presence here indicates your profound interest in the important subject we have under consideration and investigation and it indicates the manifest interest that the Province of Manitoba has in health services. I welcome you and Dr. Johnson, the Minister of Health, because it is most encouraging to the Commission to receive the co-operation from Governments which we have been receiving.

SUBMISSION OF THE GOVERNMENT OF MANITOBA

Appearances: Hon. Duff Roblin, Premier
Dr. G. Johnson, M.D., Minister
of Health
Mr. A.V. Mauro, Counsel

MR. MAURO: Thank you, Mr. Chairman and



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Monday, January 18th,
1909.

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Mr. A.V. Mauro, Counsel

MR. MAURO: Thank you, Mr. Chairman and



Commissioners. The submission of the Province of Manitoba is in two parts, a submission by the Premier setting out generally the principles upon which the Government of the Province of Manitoba has approached the Terms of Reference in this Commission and that will be Exhibit 48.

--- EXHIBIT NO. 48: Submission of the Government of Manitoba.

THE CHAIRMAN: The submission that Dr. Johnson will be giving us will be Exhibit 49.

--- EXHIBIT NO. 49: Submission of the Minister of Health of the Province of Manitoba.

MR. MAURO: This is in somewhat greater detail, the factors involved therein. It is our plan by way of summary to carry on in question and answer form. Mr. Premier, would you commence your submission.

HON. MR. ROBLIN: Mr. Chairman and members of the Commission: I welcome you on behalf of the Province of Manitoba. The investigation which you have undertaken is of immediate and far-reaching consequences to the citizens of this province. We trust your deliberations here in the City of Winnipeg will prove useful. We assure you of our support and continuing assistance in your assessment of Canada's national health needs.

My colleague, the Minister of Health and I propose to place before you the views of the Province of Manitoba as to the existing facilities and services in this province, our proposals for their improvement and



Commissioners. The submission of the Province of Manitoba is in two parts, a submission by the Premier setting out generally the principles upon which the Government of the Province of Manitoba has approached the Terms of Reference in this Commission and that will be Exhibit #8. --- EXHIBIT NO. #8: Submission of the Government of Manitoba.

THE CHAIRMAN: The submission that Dr. Johnson will be giving us will be Exhibit #9.

--- EXHIBIT NO. #9: Submission of the Minister of Health of the Province of Manitoba.

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3 our plans for their future development. We will also
4 discuss the role which the Federal Government should play
5 in the attainment of these objectives.

6 MR. MAURO: What is the view of the
7 Province of Manitoba as to the role and function of
8 government in the health services field?

9 HON. MR. ROBLIN: I think the expanding
10 role of the Provincial Government in the field of health
11 services can best be illustrated by reference to the
12 expenditures since the establishment of a separate Depart-
13 ment of Health and Public Welfare. In 1928-1929 there
14 was expended the sum of \$1,610,000 or \$2.40 per capita.
15 In 1959-1960, total expenditures amounted to \$10,910,000
16 or \$12.12 per capita.

17 In the initial period the role of govern-
18 ment was limited to protecting the state against epidemic
19 diseases. The role of government has now developed to
20 encompass not only epidemic diseases but also preventive
21 services, and generally the physical and mental well-being
22 of its citizens.

23 In your statement at the opening of these
24 hearings in Ottawa, Mr. Chairman, you stated as follows:

25 "The view appears to be developing, taken
26 into account increasingly by governments,
27 that opportunity for good health is a
28 right possessed by all and should become
29 available in one form or another to every
30 citizen of Canada".

31 Your words represent the philosophical
32 approach of the Government of this province to the problem



our plans for their future development. We will also discuss the role which the Government has in the attainment of these objectives.

MR. MAURO: What is the view of the Province of Manitoba as to the role and function of Government in the health services field?

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3 of health and medical services for our citizens. It is
4 important in defining any philosophical approach to keep
5 in mind the proper role of government. It is our view
6 that government should be aware of the fact that it is
7 the individual who has the right and the responsibility
8 to provide for his needs. It is the Government's function
9 to assist when the individual is unable to care for
10 himself and to take full responsibility only in those
11 areas, such as the control of epidemic diseases, in which
12 the state itself has the prior interest.

13 An examination of the development of health
14 services, both provincially and federally, supports this
15 view. Initially the state's essential interest was in
16 the control of epidemic-type diseases. Subsequently,
17 with the further development of society and the emergence
18 of more complex problems, the role and function of the
19 state itself underwent change. In the most recent social
20 legislation in Manitoba, the Social Allowances Act of
21 1959, the Provincial Government and the municipalities
22 are authorized to take such measures as are necessary
23 for the purpose of ensuring that no resident of Manitoba
24 lacks "such things, goods and services as are essential
25 to his health and well-being including food, clothing,
26 shelter, and essential surgical, medical, optical, dental
27 and other remedial treatment, care and attention". This
28 Act is premised on two essential considerations. The
29 first and most important is that freedom from disease
30 and freedom from the fear of disease for our citizens
is equal to freedom from other basic wants. The second
consideration is that by taking steps to minimize disease



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3 and restore people to active and productive lives, the
4 community is strengthened.

5 The Social Allowances Act does not say
6 that the Government of Manitoba and the municipalities
7 shall provide such things, goods and services as are
8 essential to health and well-being. Rather, it sets out
9 clearly that steps may be taken that no resident shall
10 lack them. The provisions of this legislation illustrate
11 our view of the function of government. Where people,
12 individually or collectively, are meeting their health
13 needs we have no desire, or, in our view, the right to
14 intervene. Moreover, our resources are limited and the
15 demands upon them large. Our position has been well
16 stated by John Maynard Keynes:

17 "The important thing for a government is
18 not to do things which individuals are
19 doing already, and to do them a little
20 better or worse; but to do those things
21 which at present are not done at all..."

22 MR. MAURO: In this scheme you have set
23 out, what do you suggest the functions of charitable
24 institutions and voluntary organizations should be?

25 HON. MR. ROBLIN: I would like to emphasize
26 the important role played by voluntary organizations and
27 charitable institutions which have continued to assist
28 the people of our Province in the many fields of health
29 care. These organizations have aided the ill and the
30 handicapped during that period of time when state parti-
cipation was neither politically nor economically practi-
cal. This essential service continues and we do not



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4 unnecessary or unwanted. Even now with the ever-changing
5 role and function of government in this field, voluntary
6 work is often more effective than what government could
7 do if we had the resources or the desire to supplant it.
8 In many of the essential services presently provided in
9 this province, the Government has in fact become a partner
10 with these organizations and this partnership has bene-
11 fited the authorities and the public. It is our hope that
12 government participation rewards these organizations by
13 providing greater opportunity for service. In any final
14 recommendation from this Commission consideration should
15 be given to the continuing role of these voluntary
16 services.

16 MR. MAURO: In retrospect, what is the
17 opinion of the Province of Manitoba as to existing
18 national health programs?

18 HON. MR. ROBLIN: By co-operation we have
19 achieved much and the public monies have been well spent.
20 However, we are satisfied that overall services would
21 have been improved more had we been able to apply the
22 monies in different ways.

23 It is our opinion, however, that the frame-
24 work within which we have been working has been too
25 inflexible. Detailed proposals for remedying this
26 situation will be placed before you. The operation of
27 the hospital services plan has shown the need for
28 greater flexibility and the same experience applies
29 throughout the range of health services. The need for
30 particular measures will vary from province to province.



foresee a time when their contribution will be either unnecessary or unwanted. Even now with the ever-changing role and function of government in this field, voluntary work is often more effective than what government could do if we had the resources or the desire to support it. In many of the essential services presently provided in this province, the Government has in fact become a partner with these organizations and this partnership has benefited the authorities and the public. It is our hope that government participation rewards these organizations by providing greater opportunity for service. In any final recommendation from this Commission consideration should be given to the continuing role of these voluntary services.

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work within which we have been working has been too inflexible. Detailed proposals for remedying this situation will be placed before you. The operation of the hospital services plan has shown the need for greater flexibility and the same experience applies throughout the range of health services. The need for particular measures will vary from province to province.



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4 Greater flexibility in the administration and the develop-
5 ment of health services is desirable. This greater
6 degree of flexibility will assist the Federal Government
7 in achieving its objective of aiding the provinces in
8 the discharge of this common responsibility.

9 MR. MAURO: Now, you have summarized the
10 submission in Chapter 1 and I ask you now to turn to
11 Chapter 2 of your submission entitled "Improvement of
12 Health Services". As you are aware, this Commission has
13 been directed to examine, among other things, the
14 existing facilities and methods for providing personal
15 health services including prevention, diagnosis, treatment
16 and rehabilitation; methods of improving such existing
17 health services; the co-relation of any new or improved
18 program with the existing services with a view to provi-
19 ding improved health services; the present physical
20 facilities and the future requirements for the provision
21 of adequate health services; the methods of financing
22 present health care services. Would you comment briefly
23 on these aspects of the Commission's investigation?

24 HON. MR. ROBLIN: I should like to say
25 first that the Province of Manitoba is now providing a
26 wide range of health services. Any extension of present
27 services or provision of additional services must of
28 necessity be based on the administrative and technical
29 foundation already in existence. The Province of Manitoba
30 is at present utilizing in excess of 98% of the funds
available to it through Federal grants, and it is, there-
fore, understandable that we are concerned about any
scheme that will commit this province to additional



Greater flexibility in the administration and the development of health services is desirable. This greater degree of flexibility will assist the Federal Government in achieving its objective of aiding the provinces in the discharge of this common responsibility.

MR. MAURO: Now, you have summarized the submission in Chapter I and I ask you now to turn to Chapter 2 of your submission entitled "Improvement of Health Services". As you are aware, this Commission has been directed to examine, among other things, the existing facilities and methods for providing personal health services including prevention, diagnosis, treatment and rehabilitation; methods of improving such existing health services; the co-relation of any new or improved program with the existing services with a view to providing improved health services; the present physical facilities and the future requirements for the provision of adequate health services; the methods of financing present health care services. Would you comment briefly on these subjects?

MR. ROBIN: I should like to say first that the Province of Manitoba is now providing a wide range of health services. Any extension of present services or provision of additional services must of necessity be based on the administrative and technical foundation already in existence. The Province of Manitoba is at present utilizing in excess of 38% of the funds available to it through Federal grants, and it is, therefore,



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4 outlays without first completing intensive research and
5 investigation into the full operation of the present
6 schemes.

7 The Commission is aware that shareable
8 costs under the Hospital Services Act do not include
9 administrative costs and capital charges, tubercular and
10 mental care costs. Administrative costs and capital
11 charges are current expenses directly related to the
12 provision of hospital services. In the current year
13 they totalled \$3,250,000. These costs are supported by
14 provincial resources alone. Our position was expressed
15 at the Dominion Provincial Conference in July of this
16 year.

17 "Mental and tuberculosis hospital care
18 seems to us to be properly part of a
19 comprehensive hospital insurance program.
20 The problems of capital cost depreciation
21 and the amortization of debt would also
22 seem to be properly included in the
23 shared responsibilities, along with rele-
24 vant administrative charges, forming as
25 they do a substantial part of direct
26 provincial costs that we believe should
27 be fully shareable".

28 The treatment and control of tuberculosis
29 and mental illnesses require imaginative programs in
30 both care and facilities. At present the cost to the
Province of Manitoba for unshared tuberculosis treatment
amounts to nearly \$900,000 annually. In the case of
mental illnesses the Province of Manitoba will spend



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3 nearly \$6,000,000 in the current estimate year. Of this
4 amount the Federal Government's contribution, through
5 mental health grants, is \$454,000. In the field of
6 hospital construction the Federal grant has been limited
7 to \$2,000 per bed when in fact the average costs over
8 the past ten years have exceeded \$10,000 per bed. This
9 deficiency in assistance has placed an undue burden on
10 provincial resources. It is also our opinion that less
11 expensive facilities will more effectively fill the needs
12 of more particular patients. Alternative care must be
13 within the scope of hospital insurance and to be fully
14 adequate must be co-ordinated with laboratory and the
15 other services of general hospitals. To date the Federal
16 Government has not paid its proper share of the develop-
17 ment of these alternative care facilities. Unless these
18 alternative care facilities are developed it will cost
19 the Federal and Provincial Governments more money. The
20 public will receive expensive services which they do not
21 require and will lack less expensive services which are
22 urgently required. While this program will have the
23 effect of reducing the overall per-patient cost, nonethe-
24 less, large sums of money are required in the initial
25 stages. The Province has made a start but the Federal
26 Government must assume its proper share if the program
27 is to succeed.

28 From the economic and therapeutic aspect
29 the treatment of the chronically ill must enable these
30 individuals to lead a more active and productive life.
The Federal Government has, through the provision of grants
in aid, participated in the establishment in Manitoba of





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4 500 beds for the chronically ill. Our studies indicate,
5 however, that what is required in Manitoba is a provision
6 of motel-hotel type units rather than the addition of
7 beds in chronic hospitals.

8 We have referred to the important role
9 which charitable and voluntary organizations have played
10 in the development of health services in the Province.
11 In this field of the chronically ill and the aged these
12 organizations have a particularly important role to
13 perform. It is our considered opinion that their function
14 will be seriously curtailed unless monies are made
15 available to them under the provisions of the National
16 Housing Act.

17 MR. MAURO: What is the situation of those
18 residents in the province unable to pay for essential
19 services?

20 HON. MR. ROBLIN: For those who are unable
21 to pay for essential services the Government and the
22 municipalities under the Social Allowances Act have made
23 arrangements since July, 1960 to provide medical, dental
24 and optical services, drugs and other medically-prescribed
25 services. The professions and government concerned
26 share the costs. Through co-operation of government
27 and the professions we have extended a wide range of
28 care to persons in need. Much credit is due to the
29 professions involved.

30 The Province presently provides free
dental services under its Medicare program. We also
operate dental clinics in the rural areas. Preventive
work in this field will yield high returns. Federal



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3 assistance is necessary if our plans are to proceed.

4 MR. MAURO: Would you put on the record
5 the recommendations of the province as to the improvement
6 of existing facilities?

7 HON. MR. ROBLIN: There are eleven points
8 we would like to make in this connection:

9 1. Public Health Service Grants should be
10 increased to reflect increased costs.

11 2. The costs of the treatment of mental
12 illnesses should be borne on a 50-50 basis
13 between the Federal and Provincial Authori-
ties.

14 3. The costs of the operation of tuber-
15 cular hospitals and care should be shared
16 on a 50-50 basis.

17 4. Under the Hospital Services Plan there
18 should be a 50-50 sharing on depreciation,
19 interest and administration charges.

20 5. A new formula be devised for hospital
21 construction grants based on a 40 per cent
22 Provincial contribution, a 40 per cent
23 Federal contribution and a 20 per cent
Municipal contribution.

24 6. The Province should be allowed to
25 specify certain non-hospital services
26 under the plan such as day hospitals,
27 half-way houses, rehabilitation and out-
28 patient therapy, home nursing services,
29 drug therapy outside of the hospitals, to
30 allow greater flexibility.

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4 7. A new policy is required for financing
5 the construction of nursing homes by
6 charitable and non-profit organizations.

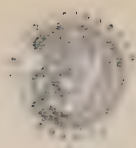
7 We suggest that this might be accomplished
8 by an amendment to the National Housing
9 Act to provide that where the sponsoring
10 group can contribute 20 per cent of the
11 estimated cost, the balance be financed
12 through this statute.

13 8. Central Mortgage and Housing Corpora-
14 tion be permitted to finance the necessary
15 costs of the construction of hostels as
16 distinguished from residences.

17 9. Federal health grants should be subject
18 to an escalator clause to match rising
19 costs in providing services.

20 10. The costs of providing Medi-Care in
21 the Province of Manitoba should be shared
22 on a 50-50 basis.

23 11. That the Federal Government provide
24 a per capita grant of 50¢ for the improve-
25 ment of dental services in the province.
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7. A new policy is required for financing the construction of nursing homes by charitable and non-profit organizations. We suggest that this might be accomplished by an amendment to the National Housing Act to provide that where the sponsoring group can contribute 20 per cent of the estimated cost, the balance be financed through this statute.
8. Central Mortgage and Housing Corporation be permitted to finance the necessary costs of the construction of hostels as distinguished from residences.
9. Federal health grants should be subject to an escalator clause to match rising costs in providing services.
10. The costs of providing Medi-Care in the Province of Manitoba should be shared on a 50-50 basis.
11. That the Federal Government provide a per capita grant of \$04 for the improvement of dental services in the province.



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4 MR. MAURO: Now, Mr. Premier, we turn to
5 a consideration of Chapter III, entitled Requirements
6 for Medical Care. You have up to this point discussed
7 the general background of the development of health
8 services, sketched briefly the existing facilities in
9 the Province of Manitoba, and expressed the views of
10 your Government and recommendations for the extension
11 and improvement of these facilities.

12 Would you now express the views of your
13 Government of the need for an extended or new program,
14 and the method of financing any such new or extended
15 program?

16 HON. MR. ROBLIN: I should like to commence
17 this with a quotation from you, Mr. Chairman, during the
18 hearing in Ottawa:

19 "When protracted illness, accidents or
20 disease strike a family, the cost of
21 medical care, hospitalization, nursing,
22 drugs and other services may be so high
23 as to represent a serious financial
24 burden in cases where no, or inadequate
25 protection is provided".

26 That is the end of your statement.

27 You discussed the impact of such illness
28 on the individual, his family and the nation at large.
29 We have, up to this point, discussed the action taken by
30 Governments, both Federal and Provincial, in dealing with
the general problem of hospitalization of Canadians.
We now turn to the parallel problem of medical care.
Both hospital and medical care are essential to the good

MR. MAURO: Now, Mr. Premier, we turn to

a consideration of Chapter III, entitled Requirements for Medical Care. You have up to this point discussed the general background of the development of health services, sketched briefly the existing facilities in the Province of Manitoba, and expressed the views of your Government and recommendations for the extension and improvement of these facilities.

Would you now express the views of your Government of the need for an extended or new program, and the method of financing any such new or extended programs?

HON. MR. ROBIN: I should like to commence

this with a quotation from you, Mr. Chairman, during the hearing in Ottawa:

"When protracted illness, accidents or disease strike a family, the cost of drugs and other services may be so high as to represent a serious financial burden in cases where no, or inadequate protection is provided."

That is the end of your statement.

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on the individual, his family and the nation at large. We have, up to this point, discussed the action taken by Governments, both Federal and Provincial, in dealing with the general problem of hospitalization of Canadians. We now turn to the parallel problem of medical care. Both hospital and medical care are essential to the good



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3 health of our citizens.

4 The approach of the Government of Manitoba
5 to this problem is that the function of government is to
6 meet those needs which are not adequately met by existing
7 organizations or schemes. We repeat that where existing
8 organizations can assist in meeting these requirements
9 governments, both Federal and Provincial, should join
10 with these organizations so that through partnership and
11 co-operation the most effective and efficient type of
12 care be provided at the least possible cost to the tax-
13 payer.

14 The same factors that resulted in govern-
15 ments undertaking a national hospital insurance scheme
16 exist with equal force in the field of medical coverage.
17 This urgent public need for medical care is the result of
18 the advances of medical science which make modern medicine
19 more expensive but a better buy. It is this factor of
20 ever increasing costs which now demands attention by
21 governments, both Provincial and Federal.

22 We in Manitoba have been conscious of
23 this urgent need over the past few years and have, in
24 fact, taken action to meet this requirement in a limited
25 field. Our Medi-Care programme, as we have indicated,
26 has been instituted to provide essential medical care to
27 those in need. It was our decision that we could best
28 meet these needs by co-operative arrangements with the
29 professional groups providing the services. The medical
30 profession have over the years accepted to a large degree
the responsibility of meeting the needs of the less fortu-
nate in our society, individually and through out-patient

health of our citizens.

The approach of the Government of Manitoba to this problem is that the function of government is to meet those needs which are not adequately met by existing organizations or schemes. We repeat that where existing organizations can assist in meeting these requirements governments, both Federal and Provincial, should join with these organizations so that through partnership and co-operation the most effective and efficient type of care be provided at the least possible cost to the taxpayer.

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this urgent need over the past few years and have, in fact, taken action to meet this requirement in a limited field. Our Medi-Care programme, as we have indicated, has been instituted to provide essential medical care to those in need. It was our decision that we could best meet these needs by co-operative arrangements with the professional groups providing the services. The medical profession have over the years accepted to a large degree the responsibility of meeting the needs of the less fortunate in our society, individually and through out-patient



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4 or university clinics. Much credit is due to the
5 medical, dental and other professional groups for their
6 past and present contributions to the health of our people.

7 It was our view that to preserve this
8 traditional contribution of the professional groups, we
9 should join with them in meeting this common problem.
10 Consequently, we arranged for prepaid services to be
11 made available covering medical care for those in need.
12 We also arranged for dental care, essential drugs and
13 the provision of glasses. We chose the Manitoba Medical
14 Service as our agent for the provision of medical care.
15 The Medi-Care card presented to a medical doctor, druggist,
16 dentist, optometrist or optician gives the patient the
17 right to these services. Chiropractic care is also
18 provided on approval by the Director of Welfare.

19 In addition to the Medi-Care scheme under
20 the Social Allowances Act, reference has been made to the
21 prepaid medical insurance scheme provided by the Manitoba
22 Medical Service for a large number of Manitobans. This
23 plan was initiated by the doctors of Manitoba in 1944 and
24 provides for a substantial group of our citizens. The
25 service has recently been opened in terms of coverage
26 to any resident of Manitoba who is able to pay the neces-
27 sary premiums. In addition, there are a number of
28 medical insurance plans that are made available by
29 private insurance companies, either on a group or indivi-
30 dual basis. The medical insurance scheme available
through the Manitoba Medical Service and the various
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3 While 70 per cent of the population of Greater Winnipeg
4 is covered under Manitoba Medical Service, only 40 per
5 cent of the total population of the Province is so
6 covered. Moreover, coverage is restricted to those
7 families and individuals who are in a position to meet
8 the premiums in effect. The present population of the
9 Province of Manitoba is in excess of 900,000. The Medi-
10 Care scheme under the Social Allowances Act provides
11 coverage for some 20,000 persons while the services under
12 the Manitoba Medical Service plan are utilized by approxi-
13 mately 400,000 persons. In addition, approximately
14 125,000 persons are covered by private insurance plans.
15 In total, therefore, various forms of medical insurance
16 coverage are at present utilized by approximately two-
17 thirds of the population of the Province. The balance
18 of the citizens, approximately 350,000, have as yet no
19 coverage. These individuals have the same needs and
20 requirements as those covered in the above plans.

21 One might properly ask -- why do the
22 present plans not cover this large body of Manitoba
23 citizens? In the case of Medi-Care, the plan is available
24 only to the recipients of provincial Social Allowance.
25 In the case of other insurance plans, the greater percen-
26 tage of the citizens not presently covered fall into two
27 categories: those who cannot afford the rates presently
28 charged; those who, because of their geographical loca-
29 tion, or other reasons have concluded that these rates
30 are not warranted by the services available. Moreover,
it is our view that there are many individuals who are
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While 70 per cent of the population of Greater Winnipeg is covered under Manitoba Medical Service, only 40 per cent of the total population of the Province is so covered. Moreover, coverage is restricted to those families and individuals who are in a position to meet the premiums in effect. The present population of the Province of Manitoba is in excess of 900,000. The Medical Care scheme under the Social Allowances Act provides coverage for some 20,000 persons while the services under the Manitoba Medical Service plan are utilized by approximately 400,000 persons. In addition, approximately 125,000 persons are covered by private insurance plans. In total, therefore, various forms of medical insurance coverage are at present utilized by approximately two-thirds of the population of the Province. The balance of the citizens, approximately 350,000, have as yet no coverage. These individuals have the same needs and requirements as those covered in the above plans.

One might properly ask -- why do the present plans not cover this large body of Manitoba citizens? In the case of Medi-Care, the plan is available only to the recipients of provincial Social Allowances. In the case of other insurance plans, the greater percentage of the citizens not presently covered fall into two categories: those who cannot afford the rates presently charged; those who, because of their geographical location, or other reasons have concluded that these rates are not warranted by the services available. Moreover, it is our view that there are many individuals who are subscribing to M.M.S. and other plans who find it



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3 difficult to bear the ever-increasing rates.

4 MR. MAURO: Has the Province of Manitoba
5 considered any possible solutions to this problem?

6 HON. MR. ROBLIN: It is our opinion that
7 medical coverage should be available to all citizens of
8 Manitoba. It is our further opinion that any such scheme
9 must be based on three essential principles:

- 10 1. that it be universally available
11 2. that it be at a stipulated premium
12 within the range of the great majority
13 of the citizens of Manitoba
14 3. that it be voluntary.

15 During the course of your hearings you
16 will have placed before you the two extreme viewpoints
17 on the current discussion of medical coverage. One view
18 will assert that the only successful plan is a plan that
19 is compulsory. This is the view of those who, during the
20 past generation, have come to the conclusion that there
21 is some mystical significance in the use of compulsion
22 and that compulsion of itself will guarantee success.
23 At the opposite extreme, you will hear from those who
24 say that no government initiative is required on this
25 matter, that in fact the present situation is working
26 admirably and that any individual who wants to meet the
27 costs of medical coverage can do so on his present income
28 basis.

29 The Government of Manitoba agrees with
30 neither of these extreme views. It is our conviction
that compulsion is not necessary in this case; that
compulsion will not create facilities; that compulsion



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5 encompassing and available to all. It is our experience
6 that there are many citizens in Manitoba for whom the
7 present schemes are not available; that the present
8 schemes are priced beyond their means, and among these
9 we include those persons who are not and cannot be
10 classified as indigents, but for whom coverage is essen-
11 tial. It is our proposal that prepaid medical insurance
12 be made available to all citizens of Manitoba at a price
13 within the economic resources of the citizens and regard-
14 less of their geographic location. We might achieve this
15 goal through the utilization of a vehicle such as the
16 Manitoba Medical Service.

16 We have previously referred to the excel-
17 lent performance of M.M.S. in the Province of Manitoba,
18 its unique association with the profession and its ability
19 to supply the services required. This group have had 17
20 years of experience in providing this type of service to
21 many of our citizens. We are satisfied that para-medical
22 services can be provided under the scheme proposed.

22 Based on the experience of the operation
23 of medical insurance plans in other countries, it would
24 appear that, for a scheme such as that proposed, consi-
25 deration should be given to a deterrent feature. Such a
26 deterrent would have the dual purpose of assuring a mini-
27 mum revenue to the scheme and would create a necessary
28 sense of responsibility in the users.

28 We have made reference to the well-
29 recognized national interest in the provision of health
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Based on the experience of the operation of medical insurance plans in other countries, it would appear that, for a scheme such as that proposed, consideration should be given to a deterrent feature. Such a deterrent would have the dual purpose of assuring a minimum revenue to the scheme and would create a necessary sense of responsibility in the users.

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3 services for the people of Canada. There is no need to
4 emphasize that this national interest applies equally in
5 the field of prepaid medical insurance. Our proposal
6 requires the provision of funds to cover the difference
7 between the total costs of the proposed scheme and a
8 stipulated premium to be charged to the citizens of
9 Manitoba. It is our submission that the Federal authority
10 should participate in this scheme to the extent of provi-
11 ding per capita grants to the Province of Manitoba to
12 assist in meeting these additional costs; namely, the
13 difference between the total actual cost of the scheme
14 and the subscription revenues. The Province of Manitoba
therefore recommends:

15 That a comprehensive prepaid medical
16 coverage be made available to all the
17 citizens of Manitoba on a voluntary basis:
18 That the Federal Government participate
19 in such a scheme by way of per capita
20 grants to the Province.

21 MR. MAURO: I wondered if you would pause
22 there for a moment, Mr. Premier.

23 You have set out three basic principles
24 that form the major premise for any solution in the minds
25 of the Government of Manitoba, namely universality,
26 price, and voluntary. I wonder if you might expand
27 briefly on these three principles?

28 HON. MR. ROBLIN: Taking them in that
29 order, I think the idea of universality pretty well
30 explains itself, that the nature of medical care is such
that it is required by all citizens of Manitoba, and

services for the people of Canada. There is no need to emphasize that this national interest applies equally in the field of prepaid medical insurance. Our proposal requires the provision of funds to cover the difference between the total costs of the proposed scheme and a stipulated premium to be charged to the citizens of Manitoba. It is our submission that the Federal authority should participate in this scheme to the extent of providing per capita grants to the Province of Manitoba to assist in meeting these additional costs; namely, the difference between the total actual cost of the scheme and the subscription revenues. The Province of Manitoba therefore recommends:

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order, I think the idea of universality pretty well explains itself, that the nature of medical care is such that it is required by all citizens of Manitoba, and



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3 therefore whatever plan we might devise should be
4 available to them, regardless of where they live, regard-
5 less of their age, regardless of their medical condition,
6 or indeed regardless of their income. So the concept of
7 universality of availability, in our view, is of
8 importance in this matter, but in order to make it
9 practically effective, it seems to us that consideration
10 has to be given to the question of the cost to the subscri-
11 ber to what we refer to as the stipulated price, or the
12 stipulated premium, because it seems to us that it is not
13 hard to establish a definition of need with respect to
14 those who are truly indigent, and we have attempted to
15 take care of them through our medical care program.

16 It is not necessary perhaps to concern
17 ourselves with those in the higher income brackets, but
18 we find that the vast majority of our people are in the
19 middle income brackets, and it is to them that I feel
20 we should direct our attention.

21 It seems to us that we should establish
22 a stipulated premium or cost to the subscriber which he
23 can afford to pay, but which may not necessarily be the
24 full cost of providing the service, and that it will be
25 necessary for the Government to make what I call an addi-
26 tional benefit, or provide an additional benefit, to the
27 cost of the service in order that costs may be covered
28 and that at the same time a premium struck which will be
29 within the means of the individual concerned to pay for.

30 Now, with respect to the third principle,
the voluntary principle, we think that this is of real
importance in this connection. We feel that it is not



therefore whatever plan we might devise should be available to them, regardless of where they live, regardless of their age, regardless of their medical condition, or indeed regardless of their income. So the concept of universality of availability, in our view, is of importance in this matter, but in order to make it practically effective, it seems to us that consideration has to be given to the question of the cost to the subscriber to what we refer to as the stipulated price, or the stipulated premium, because it seems to us that it is not hard to establish a definition of need in respect to those who are truly indigent, and we have attempted to take care of them through our medical care program.

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4 necessary in the concept of medical insurance in Manitoba
5 to introduce a compulsory principle. After all, we have
6 had the experience of the Manitoba Medical Service,
7 which is a remarkable one I think in many respects.
8 They have been able to secure 70% of the population of
9 Winnipeg as subscribers on a purely voluntary basis, and
10 it seems to us that in a plan which we might develop,
11 which has within it that element of Government benefit
12 that I have described, that it should not be difficult
13 or impossible for us to secure a large percentage of the
14 people of Manitoba as subscribers to a plan of that sort
15 on a voluntary basis, and that being the case we are
16 reluctant to consider a compulsory system when we feel
17 it will not be necessary under our circumstances.

18 I think there are other aspects of the
19 voluntary principle that might be mentioned too. That
20 is, there will be some people, perhaps for religious
21 reasons, and some for philosophical reasons, who will
22 regard compulsion in this respect with distaste, and if
23 it is not necessary to impose it, I think we should
24 refrain from doing so.

25 Also, I think there is not only the
26 question of the voluntary principle with respect to the
27 subscriber; there is the voluntary principle with respect
28 to the medical profession, because I think we would be
29 reluctant to consider a scheme which would amount to
30 conscription of that profession in terms of the medical
insurance plan. We feel again there is no necessity
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4 feel confident that we would be able to work out a plan
5 containing the voluntary principle with respect to the
6 medical profession.

7 With respect to other aspects, I think
8 that perhaps would be some further elaboration of our
9 thoughts in connection with these three points.

10 MR. MAURO: I also note that you use the
11 phrase, a vehicle such as the Manitoba Medical Service.
12 Would you expand on that particular phrase?

13 HON. MR. ROBLIN: Well, I don't think that
14 at the present time the Government of the Province has
15 come to any conclusions with respect to the nature or
16 the character of the vehicle that might be employed in
17 respect of medical insurance, but we do think that the
18 Manitoba Medical Service certainly is a logical point of
19 departure, one that should be considered carefully,
20 because whether we use that service as it stands or not,
21 it does I think have many points of practical application
22 in view of their very successful operation. They have
23 been working here in the Province, I think for some 17
24 years or thereabouts, and have been successful in
25 bringing care to a large number of our people. They have
26 developed a system of bringing together the user and the
27 provider of the service in a rather unique way, and it
28 seems to us that they are voluntary, and in both senses
29 of the word, in respect of the medical profession, and
30 in respect of the public, and this has enabled them to
demonstrate certain principles that we might well be able
to adopt.

MR. MAURO: What do you consider the role

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MR. MAURO: What do you consider the role



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3 of responsibility of the Federal Government in such a
4 scheme?

5 HON. MR. ROBLIN: Well, it seems to us
6 that we must look to the Federal Government for that
7 element of government benefit about which I was talking
8 when I was referring to the stipulated premium. Here
9 in the Province of Manitoba we will be expecting to
10 raise in support of this plan from our citizens, either
11 through the premium system or others, and after all,
12 regardless of whether you use the premium system or others,
13 it is the people of Manitoba who will be paying. They
14 will be asked to pay a very large share of this, but we
15 also think that we should have recourse to the national
16 sources of revenue, the national economic structure, for
17 support of this plan to a certain degree, and that is
18 why we think that it is proper for us to suggest that
19 the Federal Government ought to be asked to provide this
20 per capita allowance in order to make the additional
21 benefit of which I spoke possible.

22 We are all familiar in this Province,
23 very familiar, with the arguments that were developed in
24 the course of the Rowell-Sirois Report, and those other
25 investigations into the economic disparity between
26 different regions in Canada, and we are well aware here
27 of the force of those arguments which suggested that in
28 certain circumstances we should be able to look to the
29 national resources for the provision of certain services
30 in order that the cost be contributed to on a national
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We are all familiar in this Province, very familiar, with the arguments that were developed in the course of the Rowell-Sirois Report, and those other investigations into the economic disparity between different regions in Canada, and we are well aware here of the force of those arguments which suggested that in certain circumstances we should be able to look to the national resources for the provision of certain services in order that the cost be contributed to on a national basis. So we think that this balance of provincial support in the way I mentioned, and Federal support in



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3 the terms of capital grant, would be the proper way to
4 approach this problem.

5 MR. MAURO: Now, Mr. Premier, would you
6 turn to the conclusions of your submission. I wonder
7 if you have any additional material you wish to place
8 before the Commission?

9 HON. MR. ROBLIN: I should like to conclude
10 with these remarks, Mr. Chairman.

11 Manitoba, alone and in co-operation with
12 the Federal Government, has accomplished a great deal in
13 raising the standards of health care. This co-operation
14 has extended beyond the field of governments to that of
15 the professions, voluntary associations and individuals.
16 There still exist shortcomings. We propose to deal
17 with them with all deliberate speed. We have indicated,
18 and my Colleague, the Minister of Health, will discuss
19 in detail those areas where need for new or expanded
20 services must be preceded by research, assessment of
21 needs, planning and orderly development of facilities
22 and administration and a satisfactory adjustment of the
23 cost sharing arrangements between the Provincial and
24 Federal governments. We must ensure that personnel is
25 available.

26 The goal of government policy is to
27 provide better health services and this goal will be
28 achieved in less time and at less cost if development is
29 the result of thorough study and planned implementation.
30 Services cannot be given adequately without facilities;
they cannot be given adequately or economically without
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5 firstly, to ensure that the standards of the present
6 services are maintained; and secondly, that areas which
7 do not have the benefit of existing programmes obtain
8 them with the least possible delay. In order to achieve
9 these goals, substantial amounts of additional revenue
10 will be necessary.

11 The Government of Manitoba hopes, indeed
12 expects, that the studies and recommendations of this
13 Commission will assist us. The problem is one which may
14 vary from province to province but is of national concern.
15 When measures are introduced, they must be aided by the
16 nation as a whole.

17 There are other areas where much is needed.
18 We must extend our work in rehabilitation. We must pursue
19 slum clearance and urban renewal. We must encourage and
20 pay for research and development, extend preventive
21 services and train the men and women for the future needs
22 of our Province.

23 It is our submission that this Royal
24 Commission has been directed to determine: firstly, how
25 much of the public money is to be expended in the field
26 of health services; and secondly, how are these monies
27 to be distributed. It is not sufficient to determine
28 simply whether a particular scheme is good or bad. We
29 must go beyond this simple assessment and relate the
30 conclusions arrived at to the human values involved. We
31 must consider the productive capacity of the economy and
32 the proper function of government in its relations with
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5 ment initiative and resources. It is our obligation to
6 ensure that the millions which we spend achieve effective
7 results, because the application of limited resources in
8 one direction, of necessity, limits the efforts of govern-
9 ment in other fields. What is required is a policy that
10 recognizes the need for the conservation and improvement
11 of health so that here in Canada, with all our great
12 natural advantages, with our great opportunities of
13 developing a truly great nation, we shall have a strong,
14 a vigorous, a healthy people of whom Canada may be proud.

15 MR. MAURO: Thank you, Mr. Premier.
16 Would you please answer the questions of the Commissioners
17 and my learned friend.

18 THE CHAIRMAN: Thank you very much, Mr.
19 Premier. I take it that it is implicit in what you have
20 said that any program which the Province of Manitoba
21 envisages would be a provincial one?

22 HON. MR. ROBLIN: That is so. We feel
23 that if we are able to secure a per capita contribution
24 from the Federal Government, that we will then be able
25 to implement a plan to meet the needs of this province.

26 I think I would like to expand on that a
27 little, and say that we recognize the necessity, however,
28 of developing a provincial system that can be reasonably
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4 There is undoubtedly a necessity that
5 there should be a reasonable and sound co-operation
6 between provinces in this matter, and it seems to us
7 this is not impossible of achievement.

8 THE CHAIRMAN: Would you anticipate that
9 there could be differences in the programs of various
10 provinces and still come under that umbrella that you
11 have just mentioned?

12 HON. MR. ROBLIN: Yes, I think so: for
13 example, we know our sister Province of Saskatchewan
14 already has in the process of implementation a universal
15 compulsory scheme which represents one way of attacking
16 this problem. While there would be certain problems, I
17 do not feel they are of such a nature as to make a
18 reasonable degree of co-operation between us impossible.
19 I think there may be differences within the provinces,
20 and at the same time that there can be sufficient co-opera-
21 tion as to make relations between them satisfactory.

22 THE CHAIRMAN: Thank you, Mr. Premier.

23 COMMISSIONER McCUTCHEON: Mr. Premier, in
24 one part of your submission which you didn't deal with in
25 your evidence, you state that based on the experience in
26 the operation of medical insurance plans in other countries
27 it would appear that a scheme such as that proposed --
28 and I take it that is the scheme you are proposing --
29 consideration should be given to a deterrent feature:
30 would you expand that?

31 HON. MR. ROBLIN: Yes. There is, I think,
32 room for consideration for a deterrent depending on the
33 details of the type of scheme evolved. For example, if



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4 on the part of doctors as well as in-hospital treatment,
5 it would seem to us from the study of the Scandinavian
6 schemes that it may be advisable to have some form of
7 deterrent for house and office calls. It is a little
8 different from the hospital situation, because you are
9 sent to the hospital on the instructions of your doctor.
10 It is not really a matter of choice. Whereas, calling a
11 doctor to your house is indeed a matter of choice, and
12 we know that with some people they make the choice more
13 often than others for reasons which may or may not be
14 justified. If that were the case, there may be consi-
15 derable argument for the use of a deterrent in respect
16 of, say, house calls, and that is the general thought
17 we had in our minds when we put that item before you.

16 COMMISSIONER McCUTCHEON: You don't think
17 that would produce a tendency for the doctor to send the
18 patient to the hospital?

18 HON. MR. ROBLIN: It may very well do that,
19 but I don't worry about it because our experience with
20 the medical profession in this province is that most
21 doctors -- a very high percentage of them -- regard this
22 business of admission to the hospital pretty seriously,
23 and I do not think we have what you might call a serious
24 problem in that respect. Undoubtedly, there may be some
25 who would take that way out. I suppose there are always
26 loopholes in any plan, but I don't regard it as serious
27 in view of our experience with the hospital plan which
28 has been an excellent one.

28 COMMISSIONER McCUTCHEON: You are
29 suggesting the Federal Government contribution be on a
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4 per capita basis: that is quite a different basis from
5 the basis of the hospital insurance scheme.

6 HON. MR. ROBLIN: Indeed it is.

7 COMMISSIONER McCUTCHEON: Would you like
8 to explain to us the reason for the difference; in other
9 words, as I visualize what you are suggesting, you would
10 obtain a flat sum of money based on the population and
11 you would have the complete control of the terms of
12 your scheme provincially?

13 HON. MR. ROBLIN: Yes. What we would
14 like the Federal Government to do is give us this flat
15 sum of money calculated for purposes of convenience on
16 the per capita basis. We would then like to have the
17 privilege of devising our plan in terms of our own needs
18 in this province.

19 We do recognize the Federal Government
20 would be perhaps well within its rights in stipulating
21 conditions etc. that they might wish to attach to the
22 use of this money, but I am suggesting such conditions
23 as are stipulated should be such as to leave us elbow
24 room and freedom of action to devise our own scheme in
25 meeting our own needs within the province.

26 COMMISSIONER McCUTCHEON: In other words,
27 you would see no objection to the Federal Government
28 laying down what I might call minimum standards?

29 HON. MR. ROBLIN: Exactly.

30 COMMISSIONER McCUTCHEON: Once you apply
them, though, you want to be completely free to do more
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HON. MR. ROBLIN: Yes, and free to develop



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3 the type of system we want here.

4 I do think they might wish to say to us,
5 for example, "You have to enrol a certain percentage of
6 your population and it is up to you to get out and sell
7 it and make sure a certain percentage of your people come
8 into it before we will take part in it". I regard that
9 as a perfectly fair and valid condition for them to set.
10 They may have certain views on co-operation with other
11 provinces which I think it would be quite proper for them
12 to stipulate.

13 So, it would seem to us at this stage of
14 our discussion of the problem that the Federal Government
15 could properly lay down a set of ground rules, but in
16 such a way as to leave us reasonable elbow room in
developing our own plan.

17 COMMISSIONER McCUTCHEON: Have you at any
18 place in your submission, or will Dr. Johnson be giving
19 any estimate of what you think that per capita contribu-
tion should be?

20 HON. MR. ROBLIN: No, we will not be
21 giving any estimate of that figure. All we are interested
22 in doing at the present time is trying to establish the
23 validity of the principles on which we think the plan
24 should be based. If we can gain acceptance of this,
25 then I think there is a great deal of work to be done in
26 connection with the costs of the plan, because the
27 question of cost is related very closely indeed to the
28 type of stipulated freedom, the type of benefit assis-
29 tance the Government proposes to give to the individual
30 or to the carrier under the type of plan we envisage.



the type of system we want here.

I do think they might wish to say to us,

for example, "You have to enrol a certain percentage of

your population and it is up to you to get out and sell

it and make sure a certain percentage of your people come

into it before we will take part in it". I regard that

as a perfectly fair and valid condition for them to set.

They may have certain views on co-operation with other

provinces which I think it would be quite proper for them

to stipulate.

So, it would seem to us at this stage of

our discussion of the problem that the Federal Government

could properly lay down a set of ground rules, but in

such a way as to leave us reasonable elbow room in

developing our own plan.

COMMISSIONER McCUTCHEN: Have you at any

place in your submission, or will Dr. Johnson be giving

any estimate of what you think that per capita contribu-

tion should be?

HON. MR. ROBLIN: No, we will not be

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tance the Government proposes to give to the individual

or to the carrier under the type of plan we envisage.



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4 We have been considering half-a-dozen
5 different systems, all of which I am sure are familiar
6 to you, and we have no view at the present time which we
7 would prefer, but it seems to us if we can get the prin-
8 ciples we are trying to establish here accepted as valid
9 in this province, we can then proceed to come to closer
grips with the question.

10 COMMISSIONER McCUTCHEON: In this plan do
11 you envisage using only one carrier, or a group of
12 carriers, or carriers which may meet minimum conditions
you would lay down?

13 HON. MR. ROBLIN: That question is open.

14 COMMISSIONER BALTZAN: Mr. Chairman and
15 Mr. Premier, I thank you, and I must say I have no very
16 profound questions to ask you, but I should like to
17 comment: it appears that the Government of Manitoba very
18 definitely reaffirms the proper role of government in a
19 clear-cut fashion. For re-emphasis, I would like to
read again paragraph 10 on page 4:

20 "It is our view that governments should
21 be aware of the fact that it is the
22 individual who has the right and the
23 responsibility to provide for his needs".

24 Conversely, Mr. Premier, may I presume it
25 is proper to say the provision is for an opportunity for
26 the citizen to avail himself of good health services --
27 when the Government takes the responsibility to provide
28 that opportunity, he or she may then take his medicine
29 or leave it -- let us put it that way. He may eat too
much or go on a hunger strike; or, perhaps, drink too

different systems, all of which I am sure are familiar to you, and we have no view at the present time which we would prefer, but it seems to us if we can get the principles we are trying to establish here accepted as valid in this province, we can then proceed to come to grips with the question.

COMMISSIONER McCORMACK: In this plan do

you envisage using only one carrier, or a group of carriers, or carriers which may meet minimum conditions you would lay down?

HON. MR. ROBIN: That question is open.

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4 much of the wrong things. The right to good health is
5 too often, I presume under your declaration, God-given,
6 as for instance some congenital, hereditary and other
7 constitutional inadequacies, including uncontrollable
8 mutations or misfortunes. In other words, I take it
9 that it is not a question of providing good health
10 services, but providing an opportunity for people to
11 avail themselves of that which you plan for?

12 HON. MR. ROBLIN: I think that is a fair
13 comment, Mr. Chairman. I think I like the word "oppor-
14 tunity", but in the concept of opportunity we also have
15 to add the word "practicality". In other words, the
16 method of insurance has to be such that the individual
17 has the opportunity which he may exercise or not as he
18 wishes, and we feel we can develop a plan here which
19 most of our people would be quite happy to have, but it
20 should also be a plan that he finds within his reasonable
21 economic resources to buy. I think that is an important
22 consideration: when considering opportunity you have to
23 consider practicality as well, but I would certainly
24 agree with what you have said in respect of this matter.

25 COMMISSIONER FIRESTONE: Mr. Premier, this
26 is a very fine brief and a very helpful explanatory
27 statement you have given the Commission. Speaking for
28 myself, I like the emphasis on principles. You are quite
29 right, if we have a better understanding of the principles
30 it may be a little easier for the Commissioners to
develop some advice it may offer to the Federal Government,
and we are very grateful to you for having put so much
emphasis on these principles.

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HOW. MR. ROSS: I think that is a fair

comment, Mr. Chairman. I think I like the word "opportunity", but in the concept of opportunity we also have to add the word "practicality". In other words, the

method of insurance has to be such that the individual has the opportunity which he may exercise or not as he wishes, and we feel we can develop a plan here which most of our people would be quite happy to have, but it should also be a plan that he finds within his reasonable economic resources to buy. I think that is an important consideration: when considering opportunity you have to consider practicality as well, but I would certainly agree with what you have said in respect of this matter.

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4 May I therefore have the privilege of
5 questioning you a little more on these principles, so
6 that we may have a fuller understanding of your views
7 and those of the Province of Manitoba on the subject.

8 I am turning first to page 11 of your
9 submission in which you have set out a perspective of
10 medical care services and insurance available to the
11 people of Manitoba. You have pointed out that out of a
12 population of about 900,000 people approximately 550,000
13 are covered by various schemes. You then proceed further
14 to suggest that there are about 350,000 that have no
15 coverage at all, and you make the point in paragraph 49
16 that even among those that have some form of coverage,
17 "...that there are many citizens in Manitoba for whom
18 the present schemes are not available; that the present
19 schemes are priced beyond their means, and among these
20 we include those persons who are not and cannot be
21 classified as indigents, but for whom coverage is essen-
22 tial".

23 This is a forthright statement that does
24 the Province of Manitoba a lot of credit. You are calling
25 a spade a spade. You say, "we have some problems in
26 this field, and what are some of the best things we can
27 do about it in a practical manner?" I take it from that,
28 Mr. Premier, that your Government is in favour of a
29 comprehensive, all-inclusive program of medical care
30 services for the Province of Manitoba that follows four
principles: 1. The principle of Federal-Provincial
co-operation; 2. co-operation with the medical profession;
3. universality and comprehensiveness; and 4. the



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questioning you a little more on these principles, so that we may have a fuller understanding of your views and those of the Province of Manitoba on the subject. I am turning first to page 11 of your

medical care services and insurance available to the people of Manitoba. You have pointed out that out of a population of about 800,000 people approximately 250,000 are covered by various schemes. You then proceed further to suggest that there are about 350,000 that have no coverage at all, and you make the point in paragraph 11 that even among those that have some form of coverage, "...that there are many citizens in Manitoba for whom the present schemes are not available; that the present schemes are priced beyond their means, and among these we include those persons who are not and cannot be classified as indigents, but for whom coverage is essential".

This is a forthright statement that the Province of Manitoba a lot of credit. You are calling a spade a spade. You say, "we have some problems in this field, and what are some of the best things we can do about it in a practical manner?" I take it from that Mr. Premier, that your Government is in favour of a comprehensive, all-inclusive program of medical care services for the Province of Manitoba that follows four principles: 1. The principle of Federal-Provincial



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3 principle of efficiency and economy to the taxpayer.

4 Am I correct in this understanding?

5 HON. MR. ROBLIN: Yes, I would accept that,
6 sir.

7 COMMISSIONER FIRESTONE: If I may then
8 proceed to the three principles which you have enumerated
9 in paragraph 47 -- and I am very grateful to Mr. Mauro
10 for having asked you to elaborate it, because your elabora-
11 tion has answered most of the questions that were in our
12 minds. As you said, yourself, the principal one of
13 universal availability is fairly clear-cut, and you have
14 explained it very adequately. May I therefore come to
15 principle number two that it be on a stipulated premium
16 within the range of the great majority of the citizens
17 of Manitoba. I think in the elaboration which you
18 offered us you suggested that part of the cost or part
19 of the premium paid by those covered by the plan would
20 not necessarily cover the full cost, and there was
21 therefore a subsidy involved in operating the scheme.
22 Am I clear in this understanding?

23 HON. MR. ROBLIN: Yes, that is correct.

24 COMMISSIONER FIRESTONE: Let us assume,
25 Mr. Premier, that you strike such a premium arrangement,
26 that is, that can be afforded by the majority or a
27 great majority of the citizens of Manitoba: let us assume
28 there are people in this group that are now employed and
29 that can afford this premium. What happens as and when
30 these people become unemployed? Who will look after the
premium then? They are not medically indigent -- they
are not indigent, I should say, in the sense you cover

principle of efficiency and economy to the taxpayer.

Am I correct in this understanding?

HON. MR. ROBLIN: Yes, I would accept that.

COMMISSIONER FIRESTONE: If I may then

proceed to the three principles which you have enumerated

in paragraph #7 -- and I am very grateful to Mr. Macdonald

for having asked you to elaborate it, because your elaboration

has answered most of the questions that were in our

minds. As you said, yourself, the principal one of

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are not indigent, I should say, in the sense you cover



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4 them presently under the medical care program, but there
5 will come a time -- they have been able to pay the
6 premium while earning -- but they have lost a job and
7 they cannot pay. Who pays it?

8 HON. MR. ROBLIN: Well, there are several
9 ways, I think, in which you can tackle this. One way,
10 which I think is being used under the health plan at
11 the present time is to provide the coverage -- keep the
12 coverage in operation for a time and collect afterwards.
13 Another system is to make it on a six months in advance
14 system of payment which takes care of most types of
15 unemployment. I think if anyone fell through the grate
16 on those two, he would have to have recourse to our
17 social allowance policy in the province. I am glad you
18 raised that point, because I think it is obvious if we
19 had a system of this nature it may be that we would have
20 to enlarge the application of the Social Allowance Act
21 from the 20,000 under it now. It has only been going a
22 year, and it is growing, and I don't expect it to stop
23 growing. But, I think ultimately that will reach the
24 level which will take care of those who are in the recog-
25 nizably indigent category. I would not say I have a
26 complete answer for your question at present, but I
27 don't visualize any insuperable difficulty in getting
28 around it. I think I would prefer the six months in
29 advance system, off the cuff, because it is easier to
30 administer and involves a minimum of difficulty. We have
the same problems with the insurance systems we have
today, and it is something I cannot give the complete
solution to this morning.



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the present time is to provide the coverage -- keep the
coverage in operation for a time and collect afterwards.
Another system is to make it on a six months in advance
system of payment which takes care of most types of
unemployment. I think if anyone felt through the years
on those two, he would have to have recourse to one
social allowance policy in the province. I am glad you
raised that point, because I think it is obvious if we
had a system of this nature it may be that we would have
to enlarge the application of the social allowance Act
from the 20,000 under it now. It has only been going a
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advance system, off the cuff, because it is easier to
administer and involves a minimum of difficulty. We have
the same problems with the insurance systems we have
today, and it is reasonable to expect that the same
solution of this problem



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4 COMMISSIONER FIRESTONE: That is very
5 helpful, Mr. Premier, since you are suggesting that in
6 developing such a scheme consideration will have to be
7 given to assure the continuity of coverage of those who
8 through no fault of their own will be unable to pay the
9 premium.

10 HON. MR. ROBLIN: I think you will find
11 it is very simple, in a sense, to lay down three or four
12 principles which cover the application of a particular
13 scheme or particular service, but when you come to imple-
14 ment it you will find a great many chinks and corners
15 which are not covered by your statement of principles,
16 and you have to develop ad hoc solutions as they arise
17 and develop. We have found that to be the case with the
18 universal compulsory hospital scheme. We have had to
19 make many adjustments in the plan since it started in
20 order to take care of the inequities and socially
21 undesirable situations which are not anticipated at the
22 beginning but which make themselves known without too
23 much delay when you get started. I am sure you will
24 face exactly the same kind of question with a medical
25 plan and you will have to develop ad hoc remedies which
26 were not anticipated or, which when they arise are
27 socially undesirable.

28 COMMISSIONER FIRESTONE: This is very
29 helpful, Mr. Premier. The principle which you have
30 explained to the Commissioners is that whatever program
is developed there will be continuing coverage for those
who cannot afford the premium through no fault of their
own, and that whether it is done under the six months



COMMISSIONER FIRST: That is very helpful, Mr. Premier, since you are suggesting that in developing such a scheme consideration will have to be given to assure the continuity of coverage of those who through no fault of their own will be unable to pay the premium.

HON. MR. ROBILIN: I think you will find it is very simple, in a sense, to lay down three or four principles which cover the application of a particular scheme or particular service, but when you come to implement it you will find a great many things and concerns which are not covered by your statement of principles, and you have to develop ad hoc solutions as they arise and develop. We have found that to be the case with the universal compulsory hospital scheme. We have had to make many adjustments in the plan since it started in order to take care of the inequalities and socially undesirable situations which are not anticipated at the beginning but which make themselves known without too much delay when you get started. I am sure you will face exactly the same kind of question with a medical plan and you will have to develop ad hoc remedies which were not anticipated or, which when they arise are socially undesirable.

COMMISSIONER FIRST: This is very helpful, Mr. Premier. The principle which you have explained to the Commissioners is that wherever program is developed there will be continuing coverage for those who cannot afford the premium through no fault of their



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4 prepayment arrangement or some other arrangement, that
5 means will be found to take care of it so that the
6 approach towards universality remains.

7 HON. MR. ROBLIN: That would be one of
8 the things we would certainly try to do.

9 COMMISSIONER FIRESTONE: You mentioned the
10 Hospital Insurance and Diagnosis Act, are you satisfied
11 that this provides desirable results? Has this been a
12 useful and constructive program for the Province of
13 Manitoba under the Act?

14 HON. MR. ROBLIN: I think we must decidedly
15 agree with that.

16 COMMISSIONER FIRESTONE: Now, how are the
17 facilities provided under this Act paid for? The
18 Federal Government makes a contribution and the Provin-
19 cial Government makes a contribution; how is the Provin-
20 cial Government contribution paid?

21 HON. MR. ROBLIN: Under the Hospital
22 Services Act, as you know, the Federal Government will
23 pay a floating proportion of certain shareable costs
24 which in this province amount to something like 48% of
25 the shareable costs - let us say 50%. We are left to pay
26 the balance of the shareable costs whatever they are
27 plus the unshared costs in any way that we see fit. As
28 you know, in some provinces this is financed through a
29 sales tax and there are various other systems. In this
30 province at the present time we are financing it through
two sources; first of all from a premium that is assessed
at the rate of \$48 per year for families and \$24 per year
for single people supplemented by, first of all, a



prepayment arrangement or some other arrangement, that means will be found to take care of it so that the approach towards universality remains.

HON. MR. ROBILIN: That would be one of the things we would certainly try to do.
COMMISSIONER FIRESTONE: You mentioned the

that this provides desirable results? Has this been a useful and constructive program for the Province of Manitoba under the Act?

HON. MR. ROBILIN: I think we must necessarily agree with that.

COMMISSIONER FIRESTONE: Now, how are the facilities provided under this Act paid for? The Federal Government makes a contribution and the Provincial Government makes a contribution; how is the Provincial Government contribution paid?

HON. MR. ROBILIN: Under the Hospital Services Act, as you know, the Federal Government will pay a floating proportion of certain shareable costs which in this province amount to something like 48% of the shareable costs - let us say 50%. We are left to pay the balance of the shareable costs whatever they are plus the unshared costs in any way that we see fit. As you know, in some provinces this is financed through a sales tax and there are various other systems. In this province at the present time we are financing it through two sources; first of all from a premium that is assessed at the rate of \$48 per year for families and \$24 per year for single people supplemented by, first of all, a



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4 contribution from income and corporation taxes - we
5 raised our corporation tax 1% and we raised our personal
6 income tax 1% which is an effective rate of 6% on the
7 Federal tax. In addition to that we pay \$3,000,000 or
8 more out of every form of consolidated revenue of the
9 province in order to finance our plan. The provincial
10 source of funds is various, it is through subscribers
11 from the personal income tax who pay a very heavy surtax
12 and the corporation tax and the funds of the province
13 provide several million dollars in excess of that.

14 COMMISSIONER FIRESTONE: In brief, every-
15 one in the Province of Manitoba is covered under the
16 hospital services program and the payments are made
17 partly through payment of premiums and partly out of
18 taxes, is that right?

19 HON. MR. ROBLIN: That is right.

20 COMMISSIONER FIRESTONE: Would you say
21 that coverage under this program is compulsory?

22 HON. MR. ROBLIN: I would say so.

23 COMMISSIONER FIRESTONE: Now, why would
24 you suggest there should be a differentiation between
25 the hospital services program and the medical care program?
26 In your number three you advocate a voluntary program
27 while in the hospital services program we have one which
28 is all-inclusive and taxes are collected in one form or
29 another from most people, not necessarily income and
30 corporation taxes but sales taxes, this is for everybody
in the province, why would you make that distinction?

31 HON. MR. ROBLIN: I think I would preface
32 my remark by saying there was no Royal Commission to



contribution from income and corporation taxes - we raised our corporation tax 1% and we raised our personal income tax 1% which is an effective rate of 6% on the Federal tax. In addition to that we pay \$3,000,000 or more out of every form of consolidated revenue of the province in order to finance our plan. The provincial source of funds is various, it is through subscribers from the personal income tax who pay a very heavy surtax and the corporation tax and the funds of the province provide several million dollars in excess of that.

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4 kindly ask my opinion of what to do in the first instance
5 but now that I have the opportunity to express my opinion
6 I am glad to do so. I think that there is a difference
7 of degree although I am quite willing to admit not an
8 absolute difference in time between the two types of
9 service. I think one may look at it this way: if one
10 were trying to justify the compulsory aspect of the
11 hospital plan about which I am not keen, to be frank,
12 I think I might do so by saying you go to the hospital
13 on orders of your doctor, there is very little matter of
14 choice. You go to the hospital because there is
15 absolutely no way around it. Secondly, you may go there
16 on the orders of the state if you have an incurable
17 disease or are mentally ill or have some contagious
18 disease the state insists you get a certain type of care
19 to protect society. That is a difference, I think.

20 On the other hand, with the doctor there
21 are two aspects of the voluntary idea, the one in
22 connection with the subscriber that I have referred to
23 before and which I refer to again that every time you go
24 to the doctor you perhaps do not necessarily need to go.
25 That is why we have given some thought to the details,
26 particularly for house calls and perhaps office calls.
27 Secondly, the hospital is an institution, it is not a
28 person and a doctor is a person. You can compel an
29 institution, I think, with a good deal more justification
30 than you can the person. I like a voluntary plan of a
medical scheme as opposed to the hospital because it
does not necessarily involve the subscription of the
doctor. I frankly envisage the willing co-operation of



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3 perhaps the whole of the medical profession, I do not
4 know, but certainly the vast majority of them. I think
5 it is sounder to approach it from that point of view
6 when you do not need to have a compulsory scheme.

7 COMMISSIONER McCUTCHEON: What happens
8 when I do not pay my premiums to the hospital scheme?

9 HON. MR. ROBLIN: If you do not pay your
10 premiums to the hospitals today the probability is, the
11 fact is, the hospital will try to collect its bill from
12 you.

13 COMMISSIONER McCUTCHEON: You do not sue
14 me? Does the province sue me?

15 HON. MR. ROBLIN: If you do not pay your
16 hospital premiums is what you are getting at?

17 COMMISSIONER McCUTCHEON: Yes.

18 HON. MR. ROBLIN: The province will take
19 legal action against you to get that money.

20 COMMISSIONER McCUTCHEON: To get the
21 premium or the hospital bill?

22 HON. MR. ROBLIN: To get the premium.

23 COMMISSIONER McCUTCHEON: That must be
24 quite an administrative burden?

25 HON. MR. ROBLIN: It is quite an admini-
26 strative burden but I must say in all fairness that we
27 have developed a system of reducing the incidence of the
28 burden by persuading the municipalities to guarantee the
29 payment of their inhabitants because if they did not do
30 that we would have to pay not the premium but the
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strative burden but I must say in all fairness that we have developed a system of reducing the financial burden by persuading the municipalities to guarantee the payment of their inhabitants because if they did not do that we would have to pay not the premium but the hospital bill so it is to their advantage to guarantee it. We are under the obligation of helping these



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3 municipalities and it is quite a problem.

4 COMMISSIONER McCUTCHEON: And it illus-
5 trates the difficulties of compulsion?

6 HON. MR. ROBLIN: It is one of the diffi-
7 culties of compulsion.

8 THE CHAIRMAN: How great has been the
9 incidence of enforced collection of that kind?

10 HON. MR. ROBLIN: Well, it has not been
11 terribly great. I must say as far as we are concerned
12 I do not think we would like to rest our case for the
13 voluntary system on the basis of administrative convenience,
14 however attractive that is, or the economical base. I
15 think we have a considerably stronger basis than that
16 and that is the basis of principle that I have been
17 trying to explain this morning, the fact in our view it
18 is not the organization, but if it was organized we
19 would have to support it.

20 COMMISSIONER BALTZAN: I think you
21 distinguished between voluntary from the point of view
22 of those that are covered and voluntary from the point
23 of view of those that are providing these services, if
24 we can deal with each aspect separately. Would you say
25 that if you had a medical care program in the Province of
26 Manitoba that covers 90% or more of the population that
27 perhaps the cost of operating such a scheme on a per
28 capita basis would be lower than if you only have some-
29 thing like 40% or 45% coverage as we now have under the
30 Manitoba Medical Services Program?

31 HON. MR. ROBLIN: I think it would depend
32 to a great extent on the part of the system you decide to

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3 use. For instance, I am giving this as an illustration,
4 you might let the Manitoba Medical Service be the
5 vehicle by which this had been handled because the
6 Government would have no administrative costs. If,
7 however, you use some other system - the Australian
8 system is one by which the Government pays about half,
9 I think it is through certain approved agencies operated
10 by about 14 or 15 people at Canberra. That does not
11 involve administration costs. However, I think we must
12 admit the administration cost is somewhere and it might
13 be that greater volume might give a lower cost although
14 that does not always follow. I would like to think that
15 the introduction of a universal compulsory scheme in
16 Manitoba was more economical than the predecessor, Blue
17 Cross. I have no figures on that to support it and I
18 rather doubt it is the case. I could not answer that
19 question because I think it depends on the particular
20 circumstances; I would say it is probable but it does not
21 necessarily follow.

22 COMMISSIONER BALTZAN: You said a little
23 earlier that you would consider it fairly reasonable if
24 the Federal Government were to support certain conditions
25 as a basis for making a contribution of the type you
26 have suggested. One of those conditions you suggested,
27 while you would be following the so-called voluntary
28 principle, that one condition might well be that a large
29 proportion of the population would be covered. If these
30 requirements were that the minimum of 90% of your popula-
tion should be covered would you feel that it would be
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3 system?

4 HON. MR. ROBLIN: I would say that would
5 be too high. If I were asked to give a reasonable percen-
6 tage I might say 75% and we might very well do better
7 than that.

8 THE CHAIRMAN: As a condition of any
9 premium ---

10 HON. MR. ROBLIN: Yes, but as a condition
11 I would say 75%. Experience is a good teacher and we
12 have nothad the experience of what we could do. We are
13 looking at the record of the past but I think we could
14 with a reasonable assurance suggest a figure of 75% as
15 being within our ability to perform and it might very
16 well turn out to be better.

17 THE CHAIRMAN: Perhaps Dr. Johnson could
18 give us this information; could you give us the percen-
19 tage covered under the hospitalization scheme having in
20 mind the compulsory aspect? What is the percentage of
21 the population of Manitoba actually covered?

22 DR. JOHNSON: 99%.

23 COMMISSIONER FIRESTONE: To return to the
24 other aspect of voluntary, and that is the co-operation
25 with the medical profession, have you had in the Province
26 of Manitoba a so-called compulsory scheme or what I prefer
27 to call the universal coverage scheme with, say, the
28 cost borne by the taxpayer to avoid double collection
29 and inefficiency in collection, in what way do you feel
30 such a system would cause undue burden on the medical
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THE CHAIRMAN: Perhaps Mr. Johnson could give us this information; could you give us the percentage covered under the hospitalization scheme having in mind the compulsory aspect? What is the percentage of the population of Manitoba actually covered?

DR. JOHNSON: 90%.

COMMISSIONER FIRSTMAN: To return to the

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4 mean, for instance, the money would be collected through
5 taxes turned over, say, to the Manitoba Medical Service
6 selected agency and they would then be paying out to
7 doctors the way they are now. What would be the objection
8 to such an arrangement as far as the doctors are concerned?

9 HON. MR. ROBLIN: I think we must ask the
10 doctors to answer that question with authority. I can
11 only give views which are not authoritative from their
12 point of view because they are the people concerned. I
13 must say that the compulsory scheme will work because we
14 have seen it work in other places and we know it works
15 and it is not impossible. The point I make is that if it
16 is not essential to proceed to that degree of compulsion
17 in spite of the medical profession, why do it because the
18 profession themselves bear testimony to the fact they
19 prefer a scheme that could be described as voluntary in
20 the way I have described here. If that is the case then
21 why not use it? In addition, there are overwhelming or
22 overriding reasons why the compulsory scheme should be
23 brought in and it is on that philosophic basis I would
24 rest my case. I cannot tell you why the doctors do not
25 like it because I am not a doctor but they will be able
26 to tell you about it and they may be right or wrong. I
27 would form the philosophic judgment that I would prefer
28 the voluntary approach to this for them as well as the
29 other people unless someone can convince me that the
30 merits of the compulsory system are so great to suggest
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5 patients who are not covered if they do not wish to do so.

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7 to you, and I am sure you will ask them this question:
8 that since the Government institutions set the wages, so
9 to speak, then they civil servcize the profession. I
10 do not know what their views will be but it is possible
11 that might be one of them.

12 COMMISSIONER FIRESTONE: May I turn to
13 page 6 of your submission, paragraph 18, and you have a
14 statement in this paragraph which I quote:

15 "Through the utilization of national
16 taxing powers an approach has been made
17 to a basic minimum standard of health
18 care for all Canadians, while retaining
19 provincial responsibility and administra-
20 tion".

21 Does this sentence suggest, Mr. Premier,
22 you are in support of the development of a national
23 program which includes the basic minimum standard of
24 health care through the utilization of national taxing
25 powers?

26 HON. MR. ROBLIN: Yes, I think perhaps I
27 should give an illustration. I know my colleague goes
28 into this in some detail but we receive health grants
29 for specific projects, for instance, cancer control.
30 They give us a sum of money, so much for cancer control
and we have a pretty free rein as to what we do with that
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6 which their money is spent but they leave it to us to
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8 the best of advantage. I think we have found over the
9 years while there are certain inflexibilities in the
10 scheme as a whole to which we draw attention in our next
11 submission, by and large there has been in some other
12 aspects recognition of the advantages of having the
13 province give considerable elbow room in the development
14 of a specific program so we think those are good. In
15 fact, we are asking that they be extended.

16 COMMISSIONER FIRESTONE: If I may pursue
17 one part of that phrase "while retaining provincial
18 responsibility and administration"; I have read if the
19 Federal Government were to go to the Manitoba Government
20 and ask the Manitoba Government what carrier they would
21 recommend to carry out or administer such a medical
22 program, let us assume for discussion's sake that you
23 would say the answer is the Manitoba Medical Services.
24 Now, say the Federal Government came along and said the
25 Manitoba Medical Services is collecting premiums and
26 you feel that those premiums are somewhat on the high
27 side, and the agreement with the Manitoba Government is
28 that that is assessed and you arrive at a figure balancing
29 the cost of the program.
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4 The Federal Government then went on
5 further to say: "We will collect this money through
6 taxation, and we will pay it directly to the Manitoba
7 Medical Services". It is a purely hypothetical question,
8 sir; what would be your views on the matter? Would you
9 feel that this is going beyond the position which the
10 Federal Government occupies in the health field, if it
11 were to enter into a direct relationship with a carrier
12 designated by the Provincial Government?

13 HON. MR. ROBLIN: I think that we would
14 like first of all to be given the responsibility of
15 developing the plan which we might use within our province,
16 and if the Federal Government, in its turn, wished to
17 veto that plan or approve of it on its part because it
18 was contributing some of the money, we would have to
19 confer very seriously with them on that.

20 I think it would be better if the money
21 were given to the Province of Manitoba, as they are in these
22 other health grants, and that we were given the responsi-
23 bility of disbursing them, perhaps as the Federal Govern-
24 ment might approve.

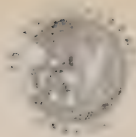
25 THE CHAIRMAN: Is there really any other
26 position, Mr. Premier, under the present constitution,
27 as it is presently in force?

28 HON. MR. ROBLIN: I would argue that there
29 is not. I would argue that this is the proper way to do
30 it.

COMMISSIONER McCUTCHEON: The only way?

HON. MR. ROBLIN: I would say that, yes.

COMMISSIONER FIRESTONE: If I may now



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COMMISSIONER FIRESTONE: If I may now



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3 proceed to another aspect. We were talking about the
4 collection of premiums to cover the part of the cost of
5 a medical care program. Now, Mr. Premier, you are aware
6 that we have in Canada several hundred plans. There is
7 first of all the co-operative plans, the commercial
8 carriers, and then there are the 11 Governments, the
9 Federal Government and ten Provincial Governments, all
10 collecting money for health purposes, and also the
11 municipalities, of which there are 4,000-plus, so there
12 are many agencies collecting in one form or another,
13 either through premiums or taxes, money for this health
14 service. When you have many agencies collecting premiums,
15 you set up a lot of administrative machinery to collect
16 it. What are your views if the Federal Government were
17 to come along and say instead of either the Manitoba
18 Government or the Manitoba Medical Service as the
19 designated agency collecting these premiums, we would
20 collect it in taxes from the taxpayers, and we would pay
21 this, through the designated agency, through the Provin-
22 cial Government along the lines that you have suggested,
23 Mr. Premier, in order to economize in the collection cost,
24 and also solve some of the problems that we have been
25 facing, that we have been discussing a little earlier,
26 what happens when people are not able to pay the premium
27 because of unemployment, etc., or the group of so-called
28 medically indigent. What are your views on this?

29 HON. MR. ROBLIN: I think that is a
30 perfectly possible way, but not one that I would prefer.
If I might relate some of my experiences since I assumed
this office, many times people come to me with what they



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4 call labour-saving devices and principles of effecting
5 economy. My great problem is to ever prove to myself,
6 or to anyone else, that the economies were ultimately
7 realized, because in setting up the new system new
8 expenses and new procedures were developed which, while
9 theoretically tending to economy, the economy was not
10 realized, so I am always sceptical of plans which are
11 devised in the interest of administrative convenience,
12 because I don't always find that that follows.

13 I think it is more important for me to
14 stick to my principles as to the type of scheme that I
15 want, rather than to be led astray into some sort of a
16 related problem, but which would have the effect of
17 destroying my principles. For example, I don't see very
18 well how I could operate the kind of plan that we have
19 sketched out for Manitoba through the system that you
20 devise. Secondly, I have no objection whatsoever to the
21 public paying a premium. In fact, I think it is sometimes
22 a sound thing that they should, because the minute it
23 goes on the tax roll, for some queer reason it becomes
24 free. Everyone who stops to think about it realizes it
25 is only free to a very few, and perhaps not even to them,
26 and it is a sound policy in some respects to have a
27 premium, from that point of view. I know that this is a
28 very interesting field of political discussion, as to
29 whether we should have a premium, or sales tax, or income,
30 or corporation tax, but at the present time I think that
there is some merit, at least let us put it that way,
some merit in considering the premium system as a means
of bringing home to the general public the fact that this

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4 belongs to them. Furthermore, it seems to me that if we
5 have a premium system working through voluntary agencies,
6 there will be some tendency on the part of the users of
7 the service to recognize that if they by their actions
8 and free costs are served, it will be reflected in the
9 premiums they pay. I think it will have the effect of
10 keeping the cost down, and have some effect on the good
11 sense of the public in the use of the plan, and for all
12 those reasons I would say that there is some merit in
13 the view that we are taking.

14 COMMISSIONER FIRESTONE: That is a very
15 constructive answer, Mr. Premier, thank you very much.
16 May I turn now to page 12 of your submission, the last
17 sentence, paragraph 52:

18 "That the Federal Government participate
19 in such a scheme by way of a per capita
20 grant to the Province".

21 You mentioned earlier that it would be
22 difficult at this stage to suggest any specific figure,
23 and we can understand that, Mr. Premier, but I take it
24 from this suggestion that you visualize a scheme where
25 a large portion of the costs are collected through
26 premiums by those that are insured, and those that can
27 afford to pay it, and that the difference be paid partly
28 through a Federal Government grant, partly through
29 taxes raised by the Province of Manitoba. Is my under-
30 standing correct?

HON. MR. ROBLIN: That is a possible
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COMMISSIONER FIRESTONE: If that were the



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COMMISSIONER FIRESTONE: That is a very

constructive answer, Mr. Premier, thank you very much. May I turn now to page 12 of your submission, the last sentence, paragraph 22:

"That the Federal Government participate in such a scheme by way of a per capita grant to the Province".

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HON. MR. ROBLIN: That is a possible

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4 case, the Province presumably has in mind that it would
5 share the cost of that difference in some form or another?

6 HON. MR. ROBLIN: I don't think that we
7 would be prepared to say what our position was on that
8 point at the present time. I think what we are saying
9 is that we would like the Federal Government to make a
10 per capita payment to the Province, and then it would be
11 left up to us to decide how we would raise the portion
12 that was required here, and we are not prepared at this
13 stage to state authoritatively how we would approach
14 this problem. There are too many unknown factors in the
15 problem to be able to do that.

16 COMMISSIONER FIRESTONE: We respect that
17 point of view, Mr. Premier, and we can understand it.
18 There are many facets to it, and you explained some of
19 them to us a little earlier. I am therefore not inquiring
20 how you would go about it and raise the funds, because it
21 is a provincial matter entirely, and we accept that, but
22 I was thinking in terms of a cost-sharing arrangement.
23 You may have some idea that the cost per capita of the
24 Federal Government would share 50%, more or less. You
25 must have an idea of what you want for an adequate or
26 sufficient amount to bring down the premium paid by
27 people to a reasonable level, so that the majority of the
28 people can afford it, so you must have some idea in mind.
29 Perhaps if it is not available now we may be advised at a
30 later stage. In trying to develop a formula, or proposals
to the Federal Government, the Commission themselves have
to make specific proposals, and if we have a better under-
standing of what the provinces feel is an equitable



case, the Province presumably has in mind that it would share the cost of that difference in some form or another.

HON. MR. ROBILIN: I don't think that we would be prepared to say what our position was on that point at the present time. I think what we are saying is that we would like the Federal Government to make a per capita payment to the Province, and then it would be left up to us to decide how we would raise the portion that was required here, and we are not prepared at this stage to state authoritatively how we would approach this problem. There are too many unknown factors in the problem to be able to do that.

COMMISSIONER FIRESTONE: we respect that point of view, Mr. Premier, and we can understand it. There are many facets to it, and you explained some of them to us a little earlier. I am therefore not indicating how you would go about it and raise the funds, because it is a provincial matter entirely, and we accept that, but I was thinking in terms of a cost-sharing arrangement. You may have some idea that the cost per capita of the Federal Government would share 50%, more or less. You must have an idea of what you want for an adequate or sufficient amount to bring down the premium paid by people to a reasonable level, so that the majority of the people can afford it, so you must have some idea in mind. Perhaps if it is not available now we may be advised at a later stage. In trying to develop a formula, or proposal to the Federal Government, the Commission themselves have to make specific proposals, and all we have a better understanding of what the provinces feel is an equitable



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4 arrangement, it would be easier for us to make suggestions,
5 and we are searching for help from them.

6 COMMISSIONER VAN WART: In the low income
7 group of provinces, would you have any objection to a
8 scheme being proposed which would take into consideration
9 the income level in the province?

10 HON. MR. ROBLIN: I think that might very
11 well be one of the schemes that are proposed. Several
12 have been suggested to us. For example, some people say
13 that any premium charged should not be more than a
14 certain percentage of the gross income, for example, two
15 or three percent, and there are others who say that the
16 best way to do this is in relating it to income tax.
17 Perhaps those who do not pay income tax should be in a
18 certain classification and others to be dealt with in
19 other ways. Then again there is the Australian system,
20 which pays no attention to any of those criteria, but
21 deals entirely with making a contribution, usually 50%,
22 to the carrier which is carrying the insurance.

23 I think what makes us relatively wide
24 open to suggestions of that nature in this province is
25 that we have our Medi-Care scheme, so that we know that
26 the people at the very bottom of the scheme are getting
27 a very comprehensive -- perhaps that word is over-used
28 nowadays -- but they are getting very full care all the
29 way through, doctors, dentists, eye glasses, chiropractic
30 service, all of the things that they might require. The
31 people at the bottom strata of our population have all
32 these things available now, because we recognize that the
33 public conscience requires that this be supplied.



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4 Incidentally, they have free choice of doctor under this
5 scheme, and this is an important thing. They can go to
6 any doctor, any dentist, or any other provider of this
7 kind of service that they wish to go to. They are not
8 directed in any way, so that they have that kind of care
9 for them at the present time, so our conscience is rela-
tively clear with respect to that type of person.

10 It might well be argued that our levels
11 are too low, and that we ought to provide this service
12 to the next classification, as you might say, and I
13 suppose if we had sufficient funds we might be tempted
14 to consider that, but having that basic coverage for
15 these people who are outside of these schemes, we feel
16 relatively free to consider any other variety of means
17 testing or needs testing, or determination of assistance
for other groups in society.

18 COMMISSIONER FIRESTONE: May I come back
19 to the question I asked earlier, and perhaps be a little
20 bit more specific, by enquiring whether it would be
21 possible for you and your colleagues in your Government,
22 or Department of Health and Welfare, to give the
23 Commission some guidance as to how you visualize this
24 per capita grant could be arrived at? You are not asking
25 at the moment for an amount, but perhaps for principles,
26 or considerations, which we should take into account as
27 reflecting your views as to what the Federal Government
28 should do. By just suggesting a per capita grant, one
29 could take any figure out of the air, and it would not be
30 really substantiated. The Commission require views and
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4 serve, what proportion of the cost it will take care of,
5 etc. In other words, can you give us some more guidance?

6 HON. MR. ROBLIN: I appreciate your
7 problem very keenly, being Provincial Treasurer, as well
8 as Premier of this province. I think we have to approach
9 the problem from various angles.

10 One that you should consider is what
11 proportion of the national income can be devoted to
12 health services. We have suggestions in this submission
13 of various kinds. It might well be that our other sugges-
14 tions might out-value the contribution we expect in
15 respect of medical insurance. I think this is the most
16 difficult task, and you have my whole sympathy, is to try
17 and decide what proportion of the national income can be
18 devoted to health services generally, and add up the
19 concrete claims, and decide how far you can go. I can
20 quite frankly say that we cannot, at this time, give you
21 a sum in the way that we could do with some of these
22 other calculations we have put before you, because our
23 own statistical information in this matter is far from
24 complete, and we say we want the Commission to tell us,
25 or we want some indication as to whether we will be
26 allowed to develop a scheme within the province on the
27 basis which I have suggested, because until we have that
28 we are going to be faced with the Martin Plan, as we were
29 previously, which was presented in this province as a
30 compulsory scheme, take it or leave it. That is one
thing, and if you have an opportunity to develop your
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5 an answer to your question. I feel it is bound up with
6 the entire problem that faces you, and I think the
7 term of reference here that asks you to look into this
8 question of the proportion of the resources of the
9 country to be made available is one of the most difficult
ones you have to deal with.

10 COMMISSIONER FIRESTONE: Thank you for
11 your sympathy, Mr. Premier. We can use it well. We
12 understand your difficulty, and we respect it, sir.
13 All I was just wondering was, not to obtain from the
14 Province of Manitoba a figure, let the Commission wrestle
15 with this figure. All I was looking for was some
16 guidance as to how to arrive at such a figure. Could we
17 leave it to you and your colleagues to advise us at some
subsequent time?

18 HON. MR. ROBLIN: We will undertake to
19 give this matter full consideration and advise you
further.

20 As I was struggling with my colleagues
21 over our brief, we were only wishing that you were
22 appearing here six months later, rather than today,
23 because we were conscious of the inadequacy of our
24 presentation, and with the other duties that devolve on
us, it is difficult to be ready in time.

25 COMMISSIONER FIRESTONE: You have done
26 wonderfully well in the time you have had at your disposal.
27 Referring to paragraph 38, in which you submit an eleven
28 point program, in which you suggest, I believe, that here
29 are some specific and complete things which the Federal
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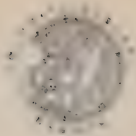
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3 Government could do, and this would be particularly
4 helpful to the development of a more comprehensive and
5 improved medical care and health service program in the
6 Province of Manitoba, would it be possible for your
7 Department to prepare some estimate of what these various
8 things might cost? Now, it may not be possible to give
9 estimates in every particular item. Where it is not
10 available you would just say so, but in some it may be,
on the basis of the 1960 and 1961 experience.

11 HON. MR. ROBLIN: Yes, we can do that, Mr.
12 Chairman, and we will be glad to give you our idea of
13 what these costs will be. This is pretty concrete. It
14 is based on past experience, and we can certainly offer
15 those figures which we shall be glad to do.

16 COMMISSIONER FIRESTONE: May I say, Mr.
17 Premier, that you have been extremely patient and very
18 constructive in your replies, and thank you very much.
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4 SUBMISSION BY HON. GEORGE JOHNSON, M.D., MINISTER
5 OF HEALTH, PROVINCE OF MANITOBA, ON BEHALF OF THE
6 GOVERNMENT OF MANITOBA

7 MR. MAURO: Dr. Johnson, the document,
8 Exhibit 49, was prepared by you or under your direction;
9 is that correct?

10 DR. JOHNSON: That is true.

11 MR. MAURO: Would you outline the nature
12 of your submission to the Commission?

13 DR. JOHNSON: Yes, Mr. Mauro.

14 Mr. Chairman, members of the Commission:
15 this submission on behalf of the Province of Manitoba,
16 reviews those areas of health and medical services in
17 which the Government of the Province has assumed a direct
18 responsibility. An evaluation of each phase of the overall
19 health and medical programmes is made in relation to
20 present and future needs of the population and specific
21 recommendations for expansion and improvement are set out.
22 In certain areas, additions to the existing programme are
23 necessary to meet the changing needs of our society and
24 specific recommendations for new measures to meet these
25 needs are made.

26 The object of our present and future health
27 and medical programme is to ensure the health of the
28 people of Manitoba by performing those services which
29 cannot be done by individuals and private agencies and
30 to assist, where necessary, individuals and agencies in a
variety of ways so that they can effectively discharge
their responsibilities.

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GOVERNMENT OF MANITOBA

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3 terms of reference emphasize the responsibility of the
4 Federal Government in the field of health services. The
5 role of the Federal Government in our present health
6 programme is reviewed and recommendations are made as to
7 its future role in the expansion of the existing programme
8 and future needed additions to this programme.

9 MR. MAURO: Dr. Johnson, Chapter I deals
10 with public health services with particular reference to
11 the whole local health units. I wonder if you could
12 advise with reference to Table I the number of citizens
13 of Manitoba served and the services rendered?

14 DR. JOHNSON: Yes, Mr. Mauro. This Table I
15 shows that exclusive of the City of Winnipeg proper the
16 local health services and local health units now serve
17 454,216 Manitobans, outside Winnipeg proper, served by
18 16 medical directors, 89 public health nurses, 31 sanitary
19 inspectors and 33 clerical staff.

20 Each full time local health unit provides
21 continuing preventive medical services and develops public
22 health programmes to meet the needs of the residents of
23 the area. In general, these units deal with such matters
24 as communicable disease control, maternal and child
25 hygiene, school health services, adult health, mental
26 health, crippled children's services, general sanitation
27 and health education.

28 By developing services such as well-baby,
29 pre-school and school clinics, large numbers of children
30 are medically examined and immunized against such diseases
as diptheria, whooping cough, tetanus, poliomyelitis,
smallpox and typhoid. Through home nursing visits,



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5 instruction classes, crippled children clinics and child
6 guidance clinics and physiotherapy clinics are provided
7 by the unit staff or in conjunction with other official
8 and voluntary agencies. A broad sanitation inspection
9 and supervision service, aimed at promoting a clean and
10 health environment, and a clean and safe supply of food,
11 milk and water is carried out and in addition, all staff
12 are engaged in a continuous public health education pro-
13 gramme to support local doctors in the prevention of
14 disease and to educate the public in good health practices.
15 In some areas private practitioners assist the staff of
16 the unit.

17 MR. MAURO: What assistance do you receive
18 from the Federal authority in providing these services?

19 DR. JOHNSON: I would refer the Commission
20 members to Tables II and III. Table II shows that between
21 the years 1955 and 60 -- the population today is 415,000
22 with a provincial expenditure of \$603,000 and Federal
23 grants totalling \$163,000. The percentage of Federal
24 to provincial outlay shows that the Federal outlay is
25 now only 25% compared to 31% five years ago.

26 Table III shows that in the total population
27 referred to earlier, this has been a population excluding
28 the City of Winnipeg proper where we have 415,000 people
29 -- and these are the 1960 figures -- and our total
30 provincial expenditure is \$603,064.18. Our expenditure
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5 expenditure of \$1.84. We point out to the Commission
6 these figures show the Federal contribution is 40¢ per
7 capita.

8 MR. MAURO: If you will turn to the
9 section on the plans for the future, I would ask you to
10 describe for the Commission the plans and ideas of your
11 Department for future development in this particular
12 field.

13 DR. JOHNSON: The traditional role of
14 public health departments and health units has been
15 directed towards the control of community situations
16 affecting health over which the individual has little or
17 no control. The earliest or sanitation phase emphasized
18 safe water, sewage disposal, etc. It was followed by the
19 communicable disease control plan dependent largely upon
20 mass immunization. Although most of these diseases are
21 now under control, neither of these phases is completed.
22 We have only recently learned to add fluorides to water,
23 to develop sewage lagoons, and to prevent poliomyelitis
24 with Salk vaccine. Not completed either is the health
25 education phase, necessary to bring about public under-
26 standing and support of these control measures.

27 A new problem has developed which cannot
28 be controlled by the individual citizen; namely the high
29 costs involved in modern medical care. The role of the
30 Health Department is therefore changing so that in addition
to preventive services and education, it is increasingly
becoming involved with "CARE".

One of the most important elements in care



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5 the introduction of the Manitoba Hospital Service Plan.
6 This plan, however, makes large demands for capital and
7 operating funds. It appears that these demands will
8 continue to increase unless the full "care" potential of
9 our communities is mobilized and coordinated so that the
10 individual receives "care" of the kind required rather
11 than the prevalent practice of treatment in high cost
12 institutions. This community based care potential
13 involves a variety of facilities including out-patient
14 departments, day hospitals, home care programmes, visiting
15 nurse service, and visiting clinics including physio-thera-
16 pists, occupational therapists, psychiatrists, etc.
17 These must be complemented by a variety of accommodation
18 facilities such as nursing homes, elderly persons'
19 residences, etc.

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21 The Local Health Units are the logical
22 agents for the coordination and support, at the local
23 level, of many of the new care programmes and activities
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26 This transition of responsibility and
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7 bed for one year is the same as the cost of acquiring
8 the services of a visiting nurse and supplying her with
9 a car. Only 50 such nurses would allow the launching of
10 a province-wide visiting nurse service. Similarly, if
11 the present localized home care programme, supporting
12 250 patients, became a province-wide service supporting
13 only 1,000 patients, it would free 150 general hospital
14 and 150 nursing home beds. The development of a proper
15 balance is not only important to proper care of the sick
16 person but also represents one of the most valuable poten-
17 tials for controlling the capital outlay required for
18 expensive institutional care.

19 MR. MAURO: What of Federal participation
20 in these plans of the Province of Manitoba?

21 DR. JOHNSON: Such an expanded role of
22 health units requires a careful review of the basis
23 upon which federal health grants are made available.
24 The present public health grants are completely utilized
25 in maintaining and strengthening conventional public
26 health preventive programmes. No support is provided
27 for expansion into a care programme. Federal support is
28 required to develop what might be called a "non-hospital"
29 service plan.

30 These new services must not be expanded
at the cost of weakening present preventive and education
programmes. They will require that the Federal Government



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DR. JOHNSON: Such an expanded role of

health units requires a careful review of the basis upon which federal health grants are made available. The present public health grants are completely utilized in maintaining and strengthening conventional public health preventive programmes. No support is provided for expansion into a care programme. Federal support is required to develop what might be called a "non-hospital" service plan.

These new services must not be expanded at the cost of weakening present preventive and education programmes. They will require that the Federal Government



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4 give the same encouragement with grants in the field of
5 CARE as are given to the existing preventive medical
6 programmes. With such assistance Manitoba can continue
7 to develop effective programmes to meet the changing
8 needs of its people in preventive medicine and care.

9 MR. MAURO: And your recommendations, Dr.
10 Johnson?

11 DR. JOHNSON: The Province of Manitoba
12 therefore recommends that the basis on which funds for
13 the Federal Health Grants programme are allocated, be
14 reassessed so as to provide sufficient revenue for the
15 Province to maintain and enhance its present programme
16 in the traditional preventive health services; and to
17 expand into areas of care towards which the Federal
18 Government does not contribute under the Hospital Insu-
19 rance and Diagnostic Services Act.

20 MR. MAURO: Before moving on to Chapter II,
21 I would like to file, Mr. Chairman, the various appendices
22 which form an integral part of this submission. My
23 colleague will distribute these. I would read into the
24 record the appendices themselves, and they will form, I
25 understand, Appendices A, B, C, and so on of Exhibit 49.

26 --- EXHIBIT NO. 49A: Map showing Health Units in Manitoba.

27 --- EXHIBIT NO. 49B: Map showing Lab. and X-ray Units
28 in Manitoba.

29 --- EXHIBIT NO. 49C: Report on Financial Estimates of
30 The Manitoba Hospital Services Plan
- for the years 1961, 1962 and 1963.

--- EXHIBIT NO. 49D: Manitoba Hospital Survey Board Report.

--- EXHIBIT NO. 49E: Narcotics Regulations - Medicare
Prescriptions.



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I would like to file, Mr. Chairman, the various appendices
which form an integral part of this submission. My
colleague will distribute these. I would read into the
record the appendices themselves, and they will form, I
understand, Appendices A, B, C, and so on of Exhibit #3.

- EXHIBIT NO. #9A: Map showing Health Units in Manitoba
- EXHIBIT NO. #9B: Map showing Lab. and X-ray Units in Manitoba.
- EXHIBIT NO. #9C: Report on Financial Estimates of The Manitoba Hospital Services Trust - for the years 1961, 1962 and 1963.
- EXHIBIT NO. #9D: Manitoba Hospital Survey Board Report



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4 --- EXHIBIT NO. 49F: Pamphlet on Health Care Services
(Medicare) under The Social
Allowances Act.
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6 --- EXHIBIT NO. 49G: List of Essential Drugs - Medicare
Program - under The Social
Allowances Act.
7 --- EXHIBIT NO. 49H: Specimen Social Allowances Medicare
Card.
8 --- EXHIBIT NO. 49I: Terms of Reference for "Teaching
Commission".
9
10 --- EXHIBIT NO. 49J: Special Article on the Home Care
Medical Program of the Winnipeg
General Hospital.
11
12 --- EXHIBIT NO. 49K: Annual Report '59-'60, Northern
Health Services.
13 --- EXHIBIT NO. 49L: The Elderly Persons Housing Act.
14 --- EXHIBIT NO. 49M: Manitoba Regulation 96/59 being a
Regulation under The Elderly Persons
Housing Act.
15 --- EXHIBIT NO. 49N: 59th Annual Report Victorian Order
of Nurses, Winnipeg Branch, 1960.
16
17 --- EXHIBIT NO. 49O: "An Ounce of Prevention" - 1960
Highlights from Annual Report of
Department of Health and Public
Welfare.
18
19 --- EXHIBIT NO. 49P: "The Manitoba Story" - Association
for Retarded Children in Manitoba.
20 --- EXHIBIT NO. 49Q: Manitoba Dental Health Index - 1960.
21 --- EXHIBIT NO. 49R: "Dental Effects of Water Fluorida-
tion" - City of Brandon Interim
Report 1955-1960.
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23

24 MR. MAURO: Dr. Johnson, your Chapter II
25 relates to Northern Health Services. I would like you
26 to refer to Exhibit 49K, and would you comment on that,
27 please? That is an annual report, 1959-60, Northern
Health Services?

28 DR. JOHNSON: That is true.

29 MR. MAURO: And that document describes
30



- 1 EXHIBIT NO. 491: Pamphlet on Health Care Services (Medicare) under The Social Allowances Act.
- 2 EXHIBIT NO. 492: List of Essential Drugs - Medicare Program - under The Social Allowances Act.
- 3 EXHIBIT NO. 493: Specimen Social Allowances Medicare Card.
- 4 EXHIBIT NO. 494: Terms of Reference for "Teaching Commission".
- 5 EXHIBIT NO. 495: Special Article on the Home Care Medical Program of the Winnipeg General Hospital.
- 6 EXHIBIT NO. 496: Health Services.
- 7 EXHIBIT NO. 497: The Elderly Persons Housing Act.
- 8 EXHIBIT NO. 498: Manitoba Regulation 96/59 being a Housing Act.
- 9 EXHIBIT NO. 499: 58th Annual Report Victorian Order of Nurses, Winnipeg Branch, 1960.
- 10 EXHIBIT NO. 500: "An Ounce of Prevention" - 1960 Highlights from Annual Report of Department of Health and Public Welfare.
- 11 EXHIBIT NO. 501: "The Manitoba Story" - Association for Retarded Children in Manitoba.
- 12 EXHIBIT NO. 502: Manitoba Dental Health Index - 1960.
- 13 EXHIBIT NO. 503: "Dental Effects of Water Fluoridation" - City of Brandon Interim Report 1955-1960.

24 MR. MAURO: Dr. Johnson, your Chapter II relates to Northern Health Services. I would like you to refer to Exhibit 494, and would you comment on that, please? That is an annual report, 1959-60, Northern

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28 DR. JOHNSON: That is true.

29 MR. MAURO: And that document describes



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2
3 the services presently conducted by the Health Department
4 under the Northern Services Branch?

5 DR. JOHNSON: Yes, that is a pamphlet
6 produced by the division of the Department of Health of
7 Northern Health Services when in 1959 we inaugurated a
8 provincial program to look after our responsibilities
9 north of the 53rd parallel, and this gives some idea of
10 the problems and how they are met in the north.

11 MR. MAURO: Do you wish to add anything
12 to the material contained in Chapter II?

13 DR. JOHNSON: I would say, Mr. Chairman
14 and members, this has been a most interesting enterprise
15 for the Province of Manitoba where we have been able to
16 eliminate much duplication by combining the activities
17 of the Federal Department of Indian and Northern Health
18 Services with the Northern Health Services program in
19 the north to offer the same program under both provincial
20 and Federal responsibility, and we have split the north
21 into east and west divisions, and there are complementary
22 services in both areas which leads, we believe, to what
23 we are recommending to the Commission.

24 MR. MAURO: Would you care to place on
25 record, Mr. Minister, the recommendation in Chapter II?

26 DR. JOHNSON: The Province of Manitoba
27 therefore recommends: that the various Provincial Programmes
28 and those of the Federal Indian and Northern Health
29 Services in remote areas be unified under Provincial
30 Health Services.

MR. MAURO: Chapter III deals with mental
hospitals and services in the Province of Manitoba. Your



the services presently conducted by the Health Department

under the Northern Services Branch?

DR. JOHNSON: Yes, that is a pamphlet

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provincial program to look after our responsibilities

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the problems and how they are met in the north.

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of the Federal Department of Indian and Northern Health

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the north to offer the same program under both provincial

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record, Mr. Minister, the recommendation in Chapter II?

DR. JOHNSON: The Province of Manitoba

therefore recommends: that the various Provincial Programs

and those of the Federal Indian and Northern Health

Health Services.

MR. MAURO: Chapter III deals with mental

hospitals and services in the Province of Manitoba. Your



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2
3 present set-up is described, and I wonder if you would
4 turn now to paragraph 53 and discuss your future plans
5 in the field of mental health services?

6 DR. JOHNSON: The Psychiatric Service
7 Division of the Department in formulating its plans for
8 the future has been guided by the principles established
9 by the Committee on Mental Health of the World Health
10 Organization.

11 Emphasis will be placed on the extension
12 of mental health programme and services into the community,
13 rather than on the building of additional institutional
14 beds. It is planned that Community Mental Health Clinics,
15 (each staffed by a psychiatrist, a psychologist, psychia-
16 tric nurses and social workers) will be provided in
17 sufficient numbers to serve the Province. It is desirable
18 that mental health be accepted by the community as an
19 integral part of the public health programme, in which
20 the local communities share responsibility for both preven-
21 tion and rehabilitation. The Local Health Units are the
22 logical agency through which the mental health clinics
23 will operate most effectively, even though the clinics
24 are hospital based and directed in policy by the Provin-
25 cial Psychiatrist.

26 The above policy will make it unnecessary
27 to further enlarge our existing mental hospitals, and
28 when further facilities are required, they will take the
29 form of small 100-bed units forming an integral part of
30 the general or extended treatment hospital.

MR. MAURO: And what is the prime need at
this time?

present set-up is described, and I wonder if you would turn now to paragraph 53 and discuss your future plans in the field of mental health services?

DR. JOHNSON: The Psychiatric Services

Division of the Department in formulating its plans for the future has been guided by the principles established by the Committee on Mental Health of the World Health Organization.

Emphasis will be placed on the extension of mental health programme and services into the community rather than on the building of additional institutional beds. It is planned that Community Mental Health Clinics (each staffed by a psychiatrist, a psychologist, psychiatric nurses and social workers) will be provided in sufficient numbers to serve the Province. It is desirable that mental health be accepted by the community as an integral part of the public health programme, in which the local communities share responsibility for both prevention and rehabilitation. The Local Health Units are the logical agency through which the mental health clinics will operate most effectively, even though the clinics are hospital based and directed in policy by the Provincial Psychiatrist.

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MR. MAURO: And what is the prime need at

this time?



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4 DR. JOHNSON: The immediate need is for
5 adequately trained staff. Greater incentives are
6 required to attract interested educated personnel into
7 the field of mental health. There is a chronic shortage
8 of fully qualified psychiatrists. This will be gradually
9 overcome by our expanded University training programme
10 which will, when fully implemented, graduate 5 certified
11 psychiatrists each year. To meet current needs in our
12 Mental Hospitals an additional 24 fully qualified psychia-
13 trists are needed immediately to staff positions presently
14 occupied by less qualified personnel. In order to fully
15 implement the newer concepts in the treatment of the
16 mentally ill, it is estimated that an additional 200
17 employees (mostly nurses, occupational therapists and
18 psychiatric social workers) are required at the present
19 time. Only by the provision of more intensive care,
20 entailing more staff, will we reach our objective of
21 reducing the need for institutional beds. The requirement
22 for qualified staff will be further intensified with the
23 continued development of community mental health clinics.
24 Mentally ill persons require care and treatment of a
25 highly skilled nature. No differentiation should be made
26 in the approach to treatment of mental illness as
27 compared to treatment of other types of illness.

28 There is no justification for the present
29 exclusion of hospital facilities for the care and treat-
30 ment of the mentally ill under the Hospital Insurance and
Diagnostic Services Act. It is anomalous that the
Federal Government should share in the cost of maintaining
senile patients under the Unemployment Assistance Act if

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adequately trained staff. Greater incentives are required to attract interested educated personnel into the field of mental health. There is a chronic shortage of fully qualified psychiatrists. This will be gradually which will, when fully implemented, graduate 5 certified psychiatrists each year. To meet current needs in our Mental Hospitals an additional 10 fully qualified psychiatrists are needed immediately to staff positions presently occupied by less qualified personnel. In order to fully implement the newer concepts in the treatment of the mentally ill, it is estimated that an additional 200 employees (mostly nurses, occupational therapists and psychiatric social workers) are required at the present time. Only by the provision of more intensive care, entailing more staff, will we reach our objective of reducing the need for institutional beds. The requirement for qualified staff will be further intensified with the continued development of community mental health clinics. Mentally ill persons require care and treatment of a highly skilled nature. No differentiation should be made in the approach to treatment of mental illness as compared to treatment of other types of illness.

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exclusion of hospital facilities for the care and treat-



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4 these patients are removed from mental hospitals and
5 placed in segregated facilities, and exclude coverage
6 if they remain in mental hospitals.

7 MR. MAURO: What was the situation in
8 regard to the psychiatric treatment of children in the
9 province?

10 DR. JOHNSON: Although service is provided
11 by the Child Guidance Clinic of Greater Winnipeg, and
12 the Psychiatric Out-Patient Department of the Children's
13 Hospital, there are no acute mental hospital facilities
14 for children other than the few beds available for this
15 purpose in general hospitals. It is planned to develop
16 a psychiatric ward at the Children's Hospital which will
17 be under the general direction of the Provincial Psychia-
18 trist.

19 MR. MAURO: Mr. Minister what is the role
20 of the Federal authorities in these plans that you have
21 set out?

22 DR. JOHNSON: All aspects of health care
23 must go forward together. We have indicated that special
24 consideration will be given to the development of a more
25 adequate mental health programme to bring it more into
26 line with the other preventive services of the Department.
27 The Province now incurs an annual expenditure of nearly
28 six million dollars of which the Health Grants provide a
29 total of \$454,000. Health is one and indivisible and it
30 is in the best interests of both the Federal and Provin-
cial Governments to promote this area of health service
and care which will result not only in better patient
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3 MR. MAURO: And what are your recommenda-
4 tions?

5 DR. JOHNSON: The Province of Manitoba
6 therefore recommends: that the cost of care in mental
7 hospitals and hospital based programmes extending into
8 the community for preventive and rehabilitation services
9 be included as a shareable cost under the Federal hospital
10 insurance plan.

11 MR. MAURO: Chapter IV is entitled "Tuber-
12 culosis Prevention and Treatment Services"; what is the
13 submission of the Province with reference to future
14 services in the case of prevention of tuberculosis?

15 DR. JOHNSON: The preventive service is
16 carried on through the co-operation of many hundreds of
17 private citizens who contribute their services during the
18 x-ray and tuberculin surveys, contribute to the prepara-
19 tion of the Christmas Seal Sale and assist in many other
20 ways. The Christmas Seal Sale is a valuable fund-raising
21 mechanism through which more than \$1,500,000 has been
22 raised during the past ten years. Even more important
23 is its use as a means of public education, which is an
24 inherent factor in a successful tuberculosis control
25 programme.

26 Unneeded tuberculosis treatment beds have
27 been converted in Manitoba to other hospital use. The
28 institutional tuberculosis treatment facilities as at
29 December 31, 1961, are estimated in Table IX.

30 MR. MAURO: Then, paragraph 77, Table IX.

DR. JOHNSON: This shows that of 393 beds
now under the Sanatorium Board of Manitoba and tuberculosis



MR. MAURO: And what are your recommendations-

DR. JOHNSON: The Province of Manitoba therefore recommends; that the cost of care in mental hospitals and hospital based programmes extending into the community for preventive and rehabilitation services be included as a shareable cost under the Federal hospital insurance plan.

MR. MAURO: Chapter IV is entitled "Tuberculosis Prevention and Treatment Services", what is the

submission of the Province with reference to future services in the case of prevention of tuberculosis? DR. JOHNSON: The preventive service is

carried on through the co-operation of many hundreds of health workers, including nurses, health visitors, x-ray and tuberculin surveys, contribute to the preparation of the Christmas Seal Sale and assist in many other ways. The Christmas Seal Sale is a valuable fund-raising mechanism through which more than \$1,500,000 has been raised during the past ten years. Even more important is its use as a means of public education, which is an inherent factor in a successful tuberculosis control programme.

Unneeded tuberculosis treatment beds have been converted in Manitoba to other hospital use. The institutional tuberculosis treatment facilities as at December 31, 1961, are estimated in Table IX.

MR. MAURO: Then, paragraph 77, Table IX.

DR. JOHNSON: This shows that of 303 beds

now under the Sanatorium Board of Manitoba and tuberculosis



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3 beds that 310 is the estimated occupancy today. I would
4 point out that a previous table shows that this is 174
5 beds less than last year.

6 MR. MAURO: 174?

7 DR. JOHNSON: 174 less than last year.

8 MR. MAURO: What of the future?

9 DR. JOHNSON: As in the case of mental
10 health and the care and treatment of patients in mental
11 hospitals, there is no justification for the exclusion
12 of the single disease of tuberculosis from the Hospital
Insurance and Diagnostic Services Act.

13 The operation of the Sanatorium Board is
14 the most dramatic example, in this Province, of achieve-
15 ment through the partnership of voluntary and governmental
16 agencies. The efforts of voluntary groups and their
17 success in helping to stamp out this dread disease,
18 serve as an inspiration to all in the health field.
19 Without such community involvement, efforts of the Depart-
20 ment of Health would have been much more difficult and
much less meaningful.

21 MR. MAURO: And what are the recommenda-
22 tions?

23 DR. JOHNSON: The Province of Manitoba
24 therefore recommends:

- 25 1. That the cost of hospital care of
26 tuberculosis patients who are presently
27 a Provincial responsibility, be included
28 as a shareable cost under the Federal
29 hospital insurance plan.
30 2. That the participation of voluntary



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The operation of the Sanatorium Board is the most dramatic example, in this Province, of achievement through the partnership of voluntary and governmental agencies. The efforts of voluntary groups and their success in helping to stamp out this dread disease, serve as an inspiration to all in the health field. Without such community involvement, efforts of the Department of Health would have been much more difficult and much less meaningful.

MR. MAURO: And what are the recommendations?

DR. JOHNSON: The Province of Manitoba

therefore recommends:

1. That the cost of hospital care of tuberculosis patients who are presently a provincial responsibility, be included as a shareable cost under the federal hospital insurance plan.
2. That the participation of voluntary



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3 bodies such as the Sanatorium Board and
4 the Christmas Seal Fund be continued as
5 an integral part of future programmes.

6 MR. MAURO: Chapter V deals with the
7 existing facilities and future requirements for institu-
8 tional care and you have filed as Appendix D the final
9 report of the Manitoba Hospital Survey Board referred to
10 as the Willard Report.

11 DR. JOHNSON: That is true.

12 MR. MAURO: As I understand it this
13 report contains a full consideration of the background
14 of the development of hospital services in Manitoba of
15 specialized and chronic disease hospitals?

16 DR. JOHNSON: That is true.

17 MR. MAURO: Would you please turn to
18 Table XIII in your submission which follows paragraph 88
19 and indicate what that table illustrates?

20 DR. JOHNSON: This table illustrates the
21 estimated Federal Government contributions to the total
22 costs of hospitalization in Manitoba including the
23 mental hospitals and tuberculosis sanatoria. This table
24 indicates that in 1961 the total of shareable hospital
25 costs was \$32,000,000 and there is a non-shareable cost
26 which is hospital plan administrative costs plus cost
27 of depreciation and interest paid by the Province and
28 not shared federally, cost \$6,085,000. You then find a
29 total cost of \$42,000,000 with the Federal share of
30 \$15,190,000 leaving a Federal percentage contribution of
total cost when you add mental and tuberculosis of 36.05%.

MR. MAURO: I understand it has been



bodies such as the Sanatorium Board and the Christmas Seal Fund be continued as an integral part of future programmes.

MR. MAURO: Chapter V deals with the existing facilities and future requirements for institutional care and you have filed as Appendix D the final report of the Manitoba Hospital Survey Board referred to as the Willard Report.

MR. MAURO: As I understand it this report contains a full consideration of the background of the development of hospital services in Manitoba of specialized and chronic disease hospitals?

DR. JOHNSON: That is true.

MR. MAURO: Would you please turn to Table XIII in your submission which follows paragraph 88 and indicate what that table illustrates?

DR. JOHNSON: This table illustrates the estimated Federal Government contributions to the total costs of hospitalization in Manitoba including the mental hospitals and tuberculosis sanatoria. This table indicates that in 1961 the total of shareable hospital costs was \$32,000,000 and there is a non-shareable cost which is hospital plan administrative costs plus cost of depreciation and interest paid by the Province and not shared federally, cost \$6,085,000. You then find a total cost of \$42,000,000 with the Federal share of \$15,190,000 leaving a Federal percentage contribution of total cost when you add mental and tuberculosis of 36.05%.

MR. MAURO: I understand it has been



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3 commonly presumed that these hospital costs are on a
4 50-50 basis?

5 DR. JOHNSON: The popular belief is that
6 they share 50% of the hospital costs and the province
7 the other 50%. Having regard to the mental and tubercular
8 sanatoria we say there is no real sound basis for this
9 and this table reveals a figure of 36% and rising
10 slightly in the next two years. The slight raise is
11 from the Province of Quebec coming into the plan and we
12 now have a proper figure for the national average which
13 means a little more money to this province. If you take
14 out mental health and tuberculosis hospital costs from
15 this picture you see that the actual costs which we are
16 getting today on acute and chronic hospitals, the
17 province's reimbursement is of the order of 40%.

18 MR. MAURO: Excluding mental and tubercular
19 care it is approximately 40%?

20 DR. JOHNSON: Right.

21 MR. MAURO: Are your estimates set out in
22 Table XIII for 1962 and '63, do they include projected
23 additions to hospital facilities as set out in the
24 Willard Report?

25 DR. JOHNSON: By and large they follow
26 that pretty closely, yes.

27 MR. MAURO: Would you now discuss Table
28 XIV which is headed "Summary of Estimated Gross Capital
29 Costs of Hospital Construction".

30 DR. JOHNSON: Yes, this is the Manitoba
Survey Board in its report which we have established
recommended an extension of facilities in the province



commonly presumed that these hospital costs are on a 50-50 basis?

DR. JOHNSON: The popular belief is that

they share 50% of the hospital costs and the province the other 50%. Having regard to the mental and tubercular sanatoria we say there is no real sound basis for this and this table reveals a figure of 38% and rising slightly in the next two years. The slight raise is from the Province of Quebec coming into the plan and we now have a proper figure for the national average which means a little more money to this province. If you take out mental health and tubercular hospital costs from this picture you see that the actual costs which we are getting today on acute and chronic hospitals, the province's reimbursement is of the order of 48%.

MR. MAURO: Excluding mental and tubercular

care it is approximately 40%.

MR. MAURO: Are your estimates set out in

Table XII for 1962 and '63, do they include projected additions to hospital facilities as set out in the

Willard Report?

DR. JOHNSON: By and large they follow

MR. MAURO: Would you now discuss Table

XIV which is headed "Summary of Estimated Gross Capital Costs of Hospital Construction".

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Survey Board in its report which we have established recommended an extension of facilities in the province



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3 over the next five years of approximately \$58,000,000.
4 Actually the Manitoba Hospital Survey Board Report
5 recommended an expenditure of \$35,000,000 over a period
6 of five or more years. When we added our mental health
7 needs to the recommendations of the Survey Board which we
8 arrived at by a separate study of our own plus the value
9 of the program which was approved prior to the Survey
10 Board beginning its study of \$15,000,000, adding the
11 \$15,000,000 and the \$8,000,000 for mental health into
12 the recommendations of the Survey Board Report of
13 \$35,000,000 the province is asked to support hospital
14 construction to the sum total of \$58,595,000. This
15 table was made up to show that with an increased provin-
16 cial contribution of hospital construction account of
17 \$1,200,000 a year then the basis for this was matched by
18 the Federal Government and following our present formula
19 in the province demanding a 20% equity from the local
20 hospitals to retain autonomy and so on, that these are
21 the figures, the monies and the sum totals of the monies
22 that would be required to be raised by each particular
23 group in order to implement this plan not in five years
24 but, as you see, in nine years.

23 MR. MAURO: And I assume, Dr. Johnson,
24 that in effect if the Willard Report were to be implemented
25 in the time suggested by that report, namely five years,
26 it would require almost a doubling up of the contributions
27 by the Federal authority?

27 DR. JOHNSON: To implement the Willard
28 Report within a five-year period would cost the Province
29 of Manitoba \$2,000,000 a year in grants which would have
30



...and the total cost of approximately \$2,000,000.

Actually the Manitoba Hospital Survey Board Report recommended an expenditure of \$35,000,000 over a period of five or more years. When we added our mental health needs to the recommendations of the Survey Board which we arrived at by a separate study of our own plus the value of the program which was approved prior to the Survey Board beginning its study of \$15,000,000, adding the \$15,000,000 and the \$8,000,000 for mental health into the recommendations of the Survey Board Report of \$35,000,000 the province is asked to support hospital construction to the sum total of \$58,500,000. This

table was made up to show that with an increased provincial contribution of hospital construction account of \$1,200,000 a year then the basis for this was matched by

the federal government. In the province demanding a 20% equity from the local hospitals to retain autonomy and so on, that these are the figures, the monies and the sum totals of the monies that would be required to be raised by each particular group in order to implement this plan not in five years but, as you see, in nine years.

MR. MAURO: And I assume, Dr. Johnson,

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DR. JOHNSON: To implement the Willard Report within a five-year period would cost the Province of Manitoba \$2,000,000 a year in grants which would have



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4 to be matched by the Federal authorities and the
5 hospitals concerned would have to agree to borrow the
6 monies on their 20% contribution.

7 MR. MAURO: At paragraph 101, would you
8 describe your future plans?

9 DR. JOHNSON: Each segment of the health
10 care programme must be considered in the context of the
11 overall programme. In this respect, because of the
12 offer of the Federal Government to share costs, the
13 Manitoba Hospital Services Plan was introduced without
14 sufficient consideration of the impact which this plan
15 would have on other elements of the care programme.

16 Hospital care is universally available on
17 a prepaid basis and there is an understandable reluctance
18 by patients to leave the hospital and face the costs of
19 care in nursing homes, hostels, boarding homes, etc.
20 This reluctance is increased in view of the fact that the
21 old age security income is not expended on care during
22 periods of stay in hospital but is consumed in the cost
23 of care in other institutions. In addition there is a
24 marked shortage of accommodation of the proper type in
25 such institutions to complement the care provided by
26 hospitals and to provide a continued programme of care
27 and treatment for patients after medical discharge from
28 hospitals.

29 The efforts of the Social Service Depart-
30 ments of hospitals are hampered by the decision of the
Federal Government that costs of this service are
shareable only to the extent that they are hospital
based. Social workers employed by hospitals are therefore



to be matched by the Federal authorities and the hospitals concerned would have to agree to borrow the

MR. MAURO: At paragraph 101, would you

describe your future plans?

DR. JOHNSON: Each segment of the health

care programme must be considered in the context of the

overall programme. In this respect, because of the

offer of the Federal Government to share costs, the

Manitoba Hospital Services Plan was introduced without

sufficient consideration of the impact which this plan

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3 unable to go outside the hospital doors to complete
4 suitable arrangements for discharged patients of hospitals.
5 The home care programmes have been effective as illustrated
6 by the programme operated by the Winnipeg General Hospital;
7 costs, however, are shareable with the Federal Government
8 only to the extent that hospital-based employees are
9 included.

10 With the rising cost of drug therapy,
11 which is an insured service to in-patients of hospitals,
12 it is apparent that medical practitioners face pressure
13 to admit patients to hospital to avoid incurring this
14 expense.

15 Difficulties have been encountered in
16 securing the prompt discharge from hospital of infants
17 awaiting adoption or foster home placement and of
18 mentally defective children. Although facilities have
19 been established at the St. Boniface Sanatorium for the
20 latter group, here again is an instance where the
21 hospital insurance plan was introduced without the
22 provision of complementary facilities essential to its
23 economical operation, and without assurance of support
24 by the Federal Government for the provision of such
25 facilities.

26 In this and other chapters of this
27 submission, we have attempted to illustrate existing gaps
28 and steps which have been taken or planned to bolster
29 the present health programme. These include preventive
30 health care, home care programmes and other services to
prevent unnecessary admission and to promote prompt
discharge from hospitals.



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4 MR. MAURO: What are your recommendations,
5 Mr. Minister?

6 DR. JOHNSON: The Province of Manitoba
7 therefore recommends:

8 1. Federal health grants be increased to
9 permit the extension of home care medical
10 programmes to a number of hospitals, parti-
11 cularly the teaching and extended treatment
12 hospitals. The present health grants are
13 fully utilized and it is only with addi-
14 tional support that increased activity in
15 this area will be possible.

16 2. The cost of pilot projects to evaluate
17 additional programmes for the care of
18 patients in their homes be included as a
19 shareable cost under the Federal hospital
20 insurance plan.

21 3. Close liaison and communication
22 between the respective Federal Departments
23 responsible for health and hospital
24 services and the Department of Health be
25 maintained and planning for future require-
26 ments integrated.

27 4. The Hospital Construction Grant be
28 revised to take into account existing costs
29 so that the Federal and Provincial Govern-
30 ments share equally 80 per cent of the
cost, the remaining sum to be raised by the
hospital proprietors and management.

5. Each year the grant available for five



MR. MAURO:

Mr. Ministers?

DR. JOHNSON: The Province of Manitoba

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3. Close liaison and communication between the respective Federal Departments responsible for health and hospital services and the Department of Health be maintained and planning for future requirements integrated.

4. The Hospital Construction Grant be revised to take into account existing costs so that the Federal and Provincial Governments share equally 80 per cent of the cost, the remaining sum to be raised by the hospital proprietors and management.

5. Each year the grant available for five



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3 years forward be made known to provincial
4 authorities by the Federal Government in
5 order to permit long-term planning.

6 6. The Federal Department of Health take
7 the initiative to arrange for the formal
8 exchange of information between the appro-
9 priate provincial bodies as to standards
10 and costs of hospital construction and
11 operation.

12 7. Costs of research be clearly segre-
13 gated from hospital operating costs and
14 adequate provision be made for this acti-
15 vity through funds of the Medical Research
16 Council and health grants.

17 8. Costs of administration of the hospital
18 services programme including the costs of
19 administrative consultants, be included as
20 shareable costs under the Federal hospital
21 insurance plan, except for costs relating
22 to the raising of Provincial monies.

23 9. Depreciation and interest costs in
24 connection with existing hospital facili-
25 ties be included as a shareable cost under
26 the Federal hospital insurance plan.

27 MR. MAURO: Now, Mr. Minister, would you
28 comment briefly on your submission regarding nursing
29 homes as contained in Chapter VI?

30 DR. JOHNSON: Until the passage of the
Social Allowances Act, in 1960, the residents in these
Homes paid for themselves or were supported by the

authorities by the Federal Government in

order to permit long-term planning.

6. The Federal Department of Health take the initiative to arrange for the formal exchange of information between the appropriate provincial bodies as to standards and costs of hospital construction and

7. Costs of research be clearly segregated from hospital operating costs and adequate provision be made for this activity through funds of the Medical Research Council and health grants.

8. Costs of administration of the hospital services programme including the costs of administrative consultants, be included as shareable costs under the Federal hospital insurance plan, except for costs relating to the raising of Provincial monies.

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DR. JOHNSON: Until the passage of the

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4 municipality or area of residence. Following the passage
5 of the above Act, the Provincial Welfare Division became
6 responsible for payment for the care of all municipal
7 cases. Approximately 2,000 of the total 3,000 residents
8 consequently became Provincial responsibilities. Concur-
9 rently, the Hospital Services Plan and general hospitals
10 increased their scrutiny and pressure for the discharge
11 of long stay cases not requiring active general hospital
12 care.

13 As prime contractor for "Nursing Home"
14 beds, the Province became directly interested and
15 involved in the type of accommodation and care given to
16 patients. A number of surveys have established:

17 1. About 2,000 of the 3,000 beds available
18 are not suitable for modern long term
19 accommodation.

20 2. In smaller homes all available space
21 tends to be used for beds so that the areas
22 vital to maintain activity are not
23 available.

24 3. Except for recently developed Elderly
25 Persons Residences, nearly all Homes
26 provide care for a mixture of the care
27 elements outlined in the foregoing. It
28 is now widely accepted that the mixing of
29 these elements results in substandard care,
30 except in large institutions where specific
areas can be set apart for specific func-
tions.

4. There is very little evidence of the

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4 use of modern geriatric principles
5 centering around "activity" in any except
6 the larger community and charitable homes.

7 To attempt to solve this care problem, a
8 new office of Alternative Care was established in November,
9 1959. Joint Health and Welfare Assessment Panels have
10 been established throughout the Province involving repre-
11 sentation from the local Health Unit and the District
12 Welfare office. These panels have met with modest
13 success in the placement of patients, but too often it
14 has been necessary to place individuals with specific
15 needs in accommodation where those needs can only be
16 partially met simply because better facilities are not
17 available.

18 MR. MAURO: Paragraph 117, what is your
19 proposed solution?

20 DR. JOHNSON: The logical sponsors of
21 accommodation for the helpless are the charitable and
22 religious groups. At present, however, there are no
23 resources to which groups of this kind can look for
24 assistance in financing new projects.

25 Five hundred replacement beds would be
26 sufficient to meet personal and nursing requirements.
27 The Residential Home needs should be met by the develop-
28 ment of Hostels under the Elderly Persons Housing Act.

29 These charitably sponsored Personal and
30 Nursing Care beds can be provided at a cost of approxi-
mately \$7,000 each, or a total of 500 beds can be
provided for on investment of \$3,500,000. If sponsors
were made responsible for providing 20 per cent of



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3 construction costs, as in the Hospital programme,
4 \$2,800,000 capital would be required from other sources.

5 If low interest, long-term loans were
6 available for this purpose, we believe that excellent
7 sponsors could be found in Manitoba. This would require
8 the provision of loans of the type now only provided by
9 the Central Mortgage and Housing Corporation, but not now
10 available for "Nursing Home" construction.

11 MR. MAURO: And your recommendations?

12 DR. JOHNSON: The Province of Manitoba
13 therefore recommends: that low interest, long-term loans
14 through Central Mortgage and Housing Corporation be made
15 available to charitable groups to construct Personal Care
and Nursing Care facilities.

16 THE CHAIRMAN: Mr. Mauro, I think we will
17 adjourn now until 2 o'clock.

18 --- Luncheon adjournment.
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THE CHAIRMAN: Mr. Mauro, I think we will

adjourn the meeting until 10:30 a.m.

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3 --- On resuming at 2:00 p.m.

4 MR. MAURO: Dr. Johnson, at the luncheon
5 break we had finished discussing the nursing home
6 problem and the recommendations of the Province of
7 Manitoba in this regard. I now ask you to turn to your
8 Chapter VII, entitled "Elderly Persons Housing", and
9 I would ask whether the same general situation that you
10 described for the nursing home problem exists with
11 reference to elderly persons housing?

12 DR. JOHNSON: Yes Mr. Mauro. The province
13 has participated in the creation of accommodation for
14 approximately 1,200 elderly citizens, about 700 hostels
15 and 500 in self-contained units. The present situation
16 in Manitoba is illustrated by Table XV, where prior to
17 1956 there were 900 hostel beds in the Province of
18 Manitoba, and the province has created 700 further beds,
19 of course in co-operation with the voluntary agencies
20 and charitable groups who are sponsoring this type of
21 housing, for a total of 1,600. This is the hostel type
22 of accommodation.

23 In self-contained housing beds, in 1956
24 there were 100, and we have created under the E.P.H. Act
25 500, for a total of 600.

26 It is difficult to estimate how much
27 housing of this kind should be created. It is important
28 to take into consideration the contribution which accommo-
29 dation, either in hostels or in self-contained units,
30 can make to the support of the elderly. In developing
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3 of accommodation. This is done because good housing is
4 preventive medicine particularly for the elderly, the
5 frail and the lonely. In particular activity and involve-
6 ment of good hostel life will inhibit deterioration
7 resulting from inactivity, poor food, isolation and
8 loneliness. We consider that about 1 out of 10 of the
9 56,000 Manitobans over 70 years of age would benefit
10 from hostel accommodation.

11 Throughout the Province, there is great
12 interest in the development by towns and municipalities
13 of modest sized hostels ranging from 30-60 beds. Interest
14 in the development of self-contained units has been much
15 less evident.

16 I would point out, particularly in rural
17 areas.

18 Central Mortgage and Housing Corporation
19 will provide long term low interest mortgages for self-
20 contained units but they will not support hostels unless
21 each hostel bed is accompanied by the coincident develop-
22 ment of one self-contained unit. Because of this conflict
23 between what communities want and what CMHC requires, it
24 has not been possible during the past two years to erect
25 a single community sponsored hostel. This is a problem
26 which is comparable to that of providing "Nursing Home"
27 facilities. Sponsors are available for this element of
28 care if they have access to CMHC type mortgages. Manitoba
29 believes that Elderly Persons Hostels represents an area
30 where community activity and support can and should be
relied upon in large measure to organize and operate
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of accommodation. This is done because good housing is preventive medicine particularly for the elderly, the frail and the lonely. In particular activity and involvement resulting from inactivity, poor food, isolation and loneliness. We consider that about 1 out of 10 of the 55,000 Manitobans over 75 years of age would benefit from hostel accommodation.

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3 cannot serve this role unless long term low cost money
4 is made available.

5 There is a chronic shortage of good accom-
6 modation for elderly persons in the Metropolitan Winnipeg
7 area, although the problem is not major in the rest of
8 the Province. In the Winnipeg area it is essential that
9 such housing be developed as close as possible to the
10 downtown area. Property in this area has become very
11 expensive so that it has been virtually impossible to
12 create low cost accommodation for the elderly by conven-
13 tional means. The solution to this impasse is the inte-
14 gration of housing for the elderly into future urban
renewal proposals.

15 MR. MAURO: And what are the recommenda-
16 tions?

17 DR. JOHNSON: The Province of Manitoba
18 therefore recommends: that low interest long term loans
19 through the Central Mortgage and Housing Corporation be
20 made available to charitable groups, voluntary organiza-
21 tions and municipalities to construct hostels for Elderly
22 Persons Housing, without matching self-contained facili-
ties.

23 MR. MAURO: Dr. Johnson, Chapter VIII is
24 entitled "Laboratory and X-Ray Units". What does the
25 present program cover?

26 DR. JOHNSON: The need for development of
27 health services in rural Manitoba led to the creation of
28 district or regional hospital and public health services
29 through legislation under The Health Services Act of 1945.
30 A significant part of this development was the provision



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MR. MAURO: And what are the recommendations?

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entitled "Laboratory and X-Ray Units". What does the present program cover?

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4 of prepaid laboratory and x-ray facilities on a regional
5 basis and an organized approach to the provision of
6 trained technical and professional services.

7 The legislation provided for the creation
8 of laboratory and x-ray facilities, adequately equipped
9 and staffed at central locations, usually in or near
10 larger rural hospitals. The area covered by each unit
11 was intended to coincide with that of the Health Unit.
12 Laboratory and X-ray services were then made available
13 to the residents of the district covered by the unit on a
14 prepaid basis, with municipal participation through normal
15 taxation levies.

16 Each unit is operated by the Provincial
17 Department of Health with an advisory board made up of
18 representatives from each of the included municipalities.
19 The provision of technical personnel and professional
20 services is the responsibility of the Department.

21 MR. MAURO: Do you anticipate an expansion
22 in this present program?

23 DR. JOHNSON: Modern medicine requires
24 full access to laboratory and radiological procedures
25 and facilities. The opinion has been expressed that the
26 development of these services should have preceded the
27 hospital insurance plan. Although Manitoba was the first
28 province in Canada to make provision for this service on
29 a prepaid basis, expansion has been gradual. The limiting
30 factors in development have been the lack of qualified
technical and professional personnel, and inadequate
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To meet the personnel problems the



of prepaid laboratory and x-ray facilities on a regional basis and an organized approach to the provision of trained technical and professional services. The legislation provided for the creation of laboratory and x-ray facilities, adequately equipped and staffed at central locations, usually in or near larger rural hospitals. The area covered by each unit was intended to coincide with that of the Health Unit. Laboratory and x-ray services were then made available to the residents of the district covered by the unit on a prepaid basis, with municipal participation through normal taxation levies.

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4 Department of Health has for the past ten years, with
5 assistance from Federal Health Grants, conducted training
6 courses for technicians of two years' duration, to
7 qualify students for recognized standing in both labora-
8 tory and X-ray procedures.

9 MR. MAURO: As I understand it, Dr.
10 Johnson, the present Hospital Insurance Act allows such
11 service on an insured basis?

12 DR. JOHNSON: The Hospital Insurance and
13 Diagnostic Services Act makes it possible to provide such
14 services on an insured basis. The next step is to explore
15 the practicability of providing diagnostic laboratory
16 and X-ray services to all residents, as an insured
17 service in an out-patient and in-patient basis. There are
18 many difficulties which must be resolved before complete
19 implementation. Existing hospital facilities in Greater
20 Winnipeg could not provide the total volume of service
21 that would be required, and it would be necessary to
22 utilize the excellent facilities now available in large
23 group practice clinics. An accelerated and consolidated
24 course of technician training must be established.
25 Sufficient professional consultant services in Radiology,
26 Bacteriology, Pathology, etc., must be arranged for,
27 under terms acceptable to the hospital insurance plan and
28 the medical profession. Manitoba is at present giving
29 detailed consideration to the development of plans for
30 the extension of these services to all residents, but the
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4 MR. MAURO: Would you state your recommen-
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6 DR. JOHNSON: The Province of Manitoba
7 therefore recommends: that the Federal Government provide
8 increased assistance through Health grants to assist in
9 training adequate numbers of personnel in this area.

10 MR. MAURO: I was wondering, just as an
11 aside on that, Dr. Johnson, do the maps that appear as
12 Appendix A and Appendix B, it is particularly Appendix B,
13 as I understand it, that will illustrate to the
14 Commission the set-up of the laboratory and x-ray units
15 in the Province?

16 DR. JOHNSON: That is true, Mr. Mauro.
17 These units at the present time, which are depicted on
18 this map, cover approximately 162,000 people in rural
19 Manitoba, at the present time.

20 MR. MAURO: Chapter IX "Rehabilitation
21 and Health Services". In this particular chapter, Mr.
22 Minister, you deal with this subject of rehabilitation
23 as setting out that this program was initiated in 1954
24 with the object of preventing disablement through early
25 and comprehensive treatment. Would you sketch briefly
26 the progress of this program to date?

27 DR. JOHNSON: Initially this programme
28 was directed to the physically disabled who could
29 reasonably be expected to be trained for a remunerative
30 occupation. It has since been expanded. This "patient
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MR. MAURO: Chapter IX "Rehabilitation and Health Services". In this particular chapter, Mr. Minister, you deal with this subject of rehabilitation as setting out that this program was initiated in 1954 with the object of preventing disablement through early and comprehensive treatment. Would you sketch briefly the progress of this program to date?

DR. JOHNSON: Initially this programme

was directed to the physically disabled who could reasonably be expected to be trained for a remunerative occupation. It has since been expanded. This "patient centred" programme is developed with four voluntary rehabilitation organizations. The disabled person is assessed from a medical, social and vocational standpoint,



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3 is assisted in the development of an individual rehabili-
4 tation plan and is helped in achieving the rehabilitation
5 objective. The four agencies co-ordinate assessment and
6 follow-up resources on behalf of the patient. Co-opera-
7 tively, they maintain contact with the patient throughout
8 the rehabilitation process and duplication has been
9 largely eliminated and more effective use has been made
10 of existing resources. This approach ensures proper
11 follow-up which is imperative in a sound rehabilitation
12 programme.

13 The four rehabilitation agencies are The
14 Canadian National Institute for the Blind, the Workmen's
15 Compensation Board, the Sanatorium Board and the Society
16 for Crippled Children and Adults.

17 Through these four agencies the physically
18 disabled of Manitoba are provided with medical rehabili-
19 tation including any medical, surgical or psychiatric
20 procedure necessary to eliminate or minimize static or
21 apparent chronic disabling conditions; provision of pros-
22 thetics including training in their use; and rehabilita-
23 tion counselling including vocational testing, pre-voca-
24 tional education, vocational training, job placement,
25 related psycho-social adjustment services and follow-up.

26 In 1960 the four agencies provided 1,500
27 disabled children and adults with rehabilitation services,
28 and 280 were rehabilitated to full time competitive
29 employment. An analysis of the activities of those fully
30 rehabilitated clearly indicates that rehabilitation of
the disabled is sound investment from an economic as well
as a humanitarian viewpoint.



is assisted in the development of an individual rehabilitation plan and is helped in achieving the rehabilitation objective. The four agencies co-ordinate assessment and follow-up resources on behalf of the patient. Co-operatively, they maintain contact with the patient throughout the rehabilitation process and duplication has been largely eliminated and more effective use has been made of existing resources. This approach ensures proper follow-up which is imperative in a sound rehabilitation programme.

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4 MR. MAURO: Dr. Johnson, as I understand
5 it, Table XVI illustrates this factor, and that table
6 should be corrected to read Analysis of Disabled Persons
7 Rehabilitated to Full-Time Employment in 1960; is that
8 correct?

9 DR. JOHNSON: Yes, this table shows that
10 last year in this province the total earnings of 280
11 rehabilitated people amounted to \$520,000. The cost of
12 services from all sources was \$104,000, and the estimated
13 annual provincial and municipal welfare savings was
14 \$65,000, and it was estimated these people pay \$32,240
15 in income tax.

16 MR. MAURO: It just about balances off?

17 DR. JOHNSON: Yes.

18 MR. MAURO: Is there anything unique in
19 this program here in Manitoba, compared with programs in
20 other parts of the country?

21 DR. JOHNSON: My understanding is that
22 the rehabilitation program in this province is unique
23 in its comprehensive nature. Through these four services
24 we have been able to render service on a most comprehen-
25 sive basis. We are tremendously grateful for the co-
26 operation of the Society for Crippled Children and Adults,
27 and these other three agencies who have worked so well to
28 co-ordinate rehabilitation in this province. We are
29 proud of our rehabilitation program to date.

30 MR. MAURO: Starting at paragraph 157,
I would ask you what effect did the introduction of the
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4 DR. JOHNSON: Following the introduction
5 of the Hospital Insurance Programme in Manitoba in 1958,
6 the need for alternative facilities for the sick and
7 disabled was examined by the Manitoba Medical Association,
8 the Provincial Government and Community Rehabilitation
9 Agencies. On the recommendation of these agencies,
10 construction of a rehabilitation hospital commenced.
11 This new facility will be completed in May 1962, and will
12 allow the transfer of certain categories of patients
13 from expensive active treatment beds to less expensive
14 rehabilitation beds. This new facility which is based
15 on a patient centred approach will provide facilities to
16 enable the disabled person to develop a practical and
17 realistic rehabilitation objective. The staff of the
18 rehabilitation hospital will work in close co-operation
19 with the four rehabilitation agencies and other govern-
20 ment and voluntary agencies. The hospital with 156 beds
21 for in-patients and facilities for 200 out-patients per
22 day, will, provide a focal point for rehabilitation in
23 Manitoba.

24
25 There is a concurrent need to ensure an
26 adequate and continuing supply of trained physiotherapists
27 and occupational therapists. The Manitoba School of
28 Physiotherapy and Occupational Therapy was established
29 in 1960. The first graduates will be available for the
30 opening of the rehabilitation hospital in 1962.

MR. MAURO: What assistance do you
presently receive from the Federal Government in this
case?

DR. JOHNSON: Financial assistance has

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5 Government through the National Health Grant Programme
6 and through various Federal-Provincial Agreements. The
7 Federal Department of Labour shares with Manitoba in the
8 cost of salaries and other expenses of the Provincial
9 Rehabilitation Co-ordinator and his staff. The Provin-
10 cial and Federal Government share equally in the cost of
11 vocational training for disabled persons, and for the
12 past six years over \$60,000 per annum has been expended
13 for this purpose.

14 Through the Medical Rehabilitation and
15 Crippled Children's Grant, the Federal Government shares
16 in the training of rehabilitation personnel, the salaries
17 and travel expenses of rehabilitation staff, and the
18 provision of direct services to individual rehabilitants.
19 This grant has aided the establishment of our School of
20 Physiotherapy and Occupational Therapy.

21 The Province of Manitoba has fully
22 utilized this grant. The ceiling imposed on this grant
23 by the federal authorities has affected further necessary
24 development of our home care programme.

25 The new Vocational Rehabilitation of
26 Disabled Persons Act, to be introduced shortly, provides
27 for unlimited flexibility in programme developments but
28 is limited to vocational rehabilitation.

29 MR. MAURO: What are your plans for the
30 future?

31 DR. JOHNSON: There is a need to extend
32 organized rehabilitation to the mentally handicapped,
33 so that only those persons requiring custodial care will



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8 reliant and useful as possible.

9 An excellent programme for medical rehabi-
10 litation of most categories of crippled children has been
11 developed through the Medical Rehabilitation and Crippled
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14 a comprehensive programme for the vocational rehabilita-
15 tion of physically disabled adults. However, the presence
16 of a ceiling on the Medical Rehabilitation Crippled
17 Children's Grant has impaired further development of our
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19 Through this new legislation, the Federal
20 Government recognizes the following principles:

21 (a) The availability of a comprehensive
22 rehabilitation programme for the whole
23 population is a sound economic investment
24 because through such a programme the
25 disabled person is provided with an oppor-
26 tunity to alter his status from economic
27 dependency to economic independence and
28 become a tax producer instead of a tax
29 consumer. The humanitarian benefits are
30 obvious.

(b) A comprehensive vocational rehabilita-
tion program cannot be developed through
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3 limitations and "ceilings".

4 (c) The Act is flexible in that it
5 permits the provinces to develop their
6 own programme at their own speed based on
7 their own available resources and in
8 accord with their particular provincial
9 characteristics.

10 MR. MAURO: This Act, as I understand it,
11 is only available to those individuals who are capable of
12 rehabilitation vocationally; is that correct?

13 DR. JOHNSON: Yes. Persons who because of
14 severe disability and/or age, are at present not consi-
15 dered satisfactory for vocational rehabilitation, none-
16 theless require rehabilitation services. The alternative
17 to a rehabilitation approach with this group will result
18 in more building of expensive active treatment and
19 extended treatment hospital beds. At present there are
20 over 400 persons benefiting from organized home care.
21 If it were not for this programme we would require
22 immediately an additional 50 active treatment beds and
23 50 nursing home beds. If these 400 patients were in
24 hospitals and nursing homes it would cost the Province
25 and the Government of Canada over \$425,000 per year, as
26 compared to \$175,000 per year for home care.

27 MR. MAURO: Who is providing the funds for
28 the Home Care Program?

29 DR. JOHNSON: Funds for home care are
30 provided from a variety of sources. For patients who
are recipients of social allowance, the Social Allowances
Act makes provision for home attendant services, home



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5 medical practitioner, medication, physiotherapy, etc.
6 The cost of these health services, with the exception of
7 home attendant services, are not shared by the government
8 of Canada. The hospital based Home Care Programme at
9 the Winnipeg General Hospital is supported by a 100%
10 Federal Health Grant with the exception of administration
11 costs which are met by the Manitoba Hospital Services
12 Plan. The Home Care Programme operated out of the
13 Co-ordinator's Office is supported by a General Public
14 Health Grant (for special equipment) and through the
15 Unemployment Assistance Agreement on a shareable basis
16 for home attendant services and by 100% provincial funds
17 for other services.

18 It is apparent that in a total rehabilita-
19 tion programme active consideration must be given to the
20 development of facilities such as half-way houses and
21 sheltered workshops. The provision of half-way houses
22 for certain categories of disabled, especially the
23 mentally disabled will not only relieve pressure on
24 existing expensive facilities, but also, will facilitate
25 the rehabilitation of the person concerned. The provision
26 of sheltered workshops will keep many disabled people
27 active and healthier thus circumventing in many instances,
28 expensive institutional care.

29 MR. MAURO: What are the recommendations
30 of the province?

31 DR. JOHNSON: That the Government of
32 Canada give consideration to new methods of equal cost
33 sharing between the Provincial and Federal Governments

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4 to strengthen existing programmes and to develop new
5 programmes (including organized home care) of a non-
6 vocational rehabilitation nature.

7 MR. MAURO: Chapter X, Mr. Minister,
8 deals with the Cancer Relief and Research Institute in
9 the province: would you briefly summarize the present
10 and future situation in the field of cancer relief and
11 research?

12 DR. JOHNSON: Since 1930, the Manitoba
13 Cancer Relief and Research Institute and its successor,
14 the Manitoba Cancer Treatment and Research Foundation
15 has pursued a programme of study, diagnosis and treatment
16 for the elimination of cancer.

17 At the present time, the Foundation
18 carries out a full service of radiotherapy within the
19 Province. There is no direct charge to patients for
20 cancer therapy excepting surgical fees. The Foundation
21 assists rural doctors in the diagnosis of cancer by its
22 biopsy service, records and registers all available
23 information on patients. It continues its radioactive
24 isotope service and has set up at the request of the
25 Minister of Health, a Radiation Protection Service
26 designed to limit, as far as possible, the danger of
27 radiation.

28 These operations are now entirely depen-
29 dent on monies provided by the Federal and Provincial
30 Governments as the Foundation no longer has the right to
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4 contributions.

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6 impose greater financial demands on the Provincial Govern-
7 ment. For example, the cost of radiotherapy will increase
8 from \$207,000 in 1951-52 to an estimated \$660,000 in
9 1962-63. During these years the Cancer Control Grant
10 has remained static at a fixed amount for Canada, distri-
11 buted on the basis of population. This has had the
12 effect of actually reducing the grant available to Mani-
13 toba from \$207,000 in 1948-49 to \$180,000 in 1962-63.
14 Although this is a matching grant, total expenditures in
15 this field now exceed three times the amount of the Grant.

15 MR. MAURO: And your recommendation?

16 DR. JOHNSON: The funds allocated to the
17 Cancer Control Grant be increased in keeping with rising
18 costs.

19 MR. MAURO: Chapter XI deals with non-
20 medical professional groups rendering health care in
21 Manitoba: you make reference to these groups. What is
22 the Government's position in regard to this matter?

23 DR. JOHNSON: The Government of Manitoba
24 feels that Manitobans have the right to seek out the care
25 and treatment they desire from any professional group.
26 The Government of Manitoba believes that the services of
27 these recognized non-medical groups are important in any
28 extension of health services. The participation of govern-
29 ment in the provision of comprehensive health services
30 necessarily involves a decision of the role of these
groups in such services, and the manner in which, if at



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3 all, they are integrated with general health care. The
4 professional standards of these groups has more than
5 local concern and Federal participation requires defini-
6 tion of the relations with these groups.

7 MR. MAURO: And the recommendation of
8 the province?

9 DR. JOHNSON: The future role of non-
10 medical groups in the health care spectrum be defined in
11 so far as government services are concerned.

12 MR. MAURO: Turning to Chapter XII,
13 Dental Health Services, what action has the Government
14 of Manitoba taken in the field of dental health services?

15 DR. JOHNSON: It was found from a sampling
16 of children that in a total population of 124,000 (64,000
17 from an area adjacent to Winnipeg and 60,000 from the
18 rest of the population) that the average child entering
19 school (age 6) had 6 decayed teeth, that 50% had poor
20 oral hygiene and 60% were growing up with some type of
21 malformation of the teeth or jaws. In addition, it was
22 determined that 40% of these children were neglected
23 dentally; 20% received minimal attention (relief of pain),
24 24% received reasonable care and only 16% received proper
25 dental care.

26 MR. MAURO: Before going on, as I under-
27 stand it, Appendix Q of the material filed this morning
28 contains all of the figures and the basis for the
29 figures that appear in paragraph 195; is that correct?

30 DR. JOHNSON: That is true.

31 MR. MAURO: And that is the Appendix
32 entitled "Manitoba Dental Health Index" -- Appendix Q?



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determined that 40% of these children were neglected dentally; 20% received minimal attention (relief of pain); 24% received reasonable care and only 16% received proper dental care.

MR. MAURO: Before going on, as I understand it, Appendix 9 of the material filed this morning contains all of the figures and the basis for the figures that appear in paragraph 195; is that correct?

DR. JOHNSON: That is true.

MR. MAURO: And that is the Appendix

entitled "Manitoba Dental Health Index" -- Appendix 9?



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4 DR. JOHNSON: Yes, that was prepared by
5 the Department of Health and by private dentists; they
6 combined their efforts to produce this index.

7 MR. MAURO: Would you carry on, Dr.
8 Johnson?

9 DR. JOHNSON: Based on these findings,
10 the Government of Manitoba supported the development of
11 a new dental school in Winnipeg with grants of over
12 \$1,000,000, shifted emphasis to preventive education.
13 In this regard, the Government recently shared in the
14 development of a Chair in Public Health Dentistry in the
15 school. Refresher courses are also provided to those in
16 practice.

17 Preventive education has also been fostered
18 at the community level. Manitoba has community water
19 fluoridation in Metropolitan Winnipeg, the cities of
20 Brandon, Portage la Prairie and the towns of Boissevain,
21 Dauphin, Killarney, Minnedosa and Steinbach, with the
22 result that Manitoba has the highest percentage of
23 population in Canada provided with fluoridated water.
24 The fluoridation of water at Brandon has been followed by
25 surveys which clearly establish fluorine's value in
26 reducing tooth decay.

27 MR. MAURO: On that matter, Mr. Minister,
28 you filed this morning an appendix marked R entitled
29 "Dental Effects of Water Fluoridation, City of Brandon,
30 Interim Report 1955-1960" and that document contains
the material which forms the footnote; is that correct?

DR. JOHNSON: Yes, that is true. It gives
the results of the five-year study of children in various



JOHNSON: Yes, that was prepared by the Department of Health and by private dentists; they combined their efforts to produce this index.

MR. MAURO: Would you carry on, Dr.

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MR. MAURO: On that matter, Mr. Minister, you filed this morning an appendix marked R entitled "Dental Effects of Water Fluoridation, City of Brandon, Interim Report 1955-1960" and that document contains the material which forms the footnote; is that correct?

DR. JOHNSON: Yes, that is true. It gives the results of the five-year study of children in various



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4 age groups showing the effects of fluoridation in the
5 water supply.

6 MR. MAURO: Would you carry on?

7 DR. JOHNSON: For preventive education
8 purposes the Province has been divided into four regions;
9 a fifth area which is region-like in organization is
10 represented by the Dental Health Division of the City of
11 Winnipeg Health Department. Each provincial region will
12 operate through the existing Local Health Units. Three
13 of the four Regional Directors, all qualified in Public
14 Health Dentistry, have already been appointed. Using
15 Dental Clinicians, Dental Hygienists and Dental Assis-
16 tants, the first target of their phased programme will
17 be preventive-interceptive care for the preschool and 6
18 year old group. A scheme for the training of Dental
19 Hygienists has been completed and should commence at the
20 Faculty of Dentistry during 1962.

21 The development of this programme is under-
22 taken concurrently with the continuation of the existing
23 programme. The Government is continuing to support and
24 encourage arrangements for the attendance of visiting
25 dentists to areas not otherwise served, sponsored by a
26 variety of community elements, Service Clubs, School
27 Boards, etcetera.

28 Recruiting for and arranging the financing
29 of the full programme present difficulties, particularly
30 as contributions from Federal sources for Public Health
Dental programmes have been very limited.

There is a need for fundamental and
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Johnson

ASSOCIATION OF DENTAL SURGEONS OF ONTARIO
TORONTO, ONTARIO

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4 for pilot studies to determine what, if any, functions
5 now performed by dentists could be delegated to auxiliary
6 personnel.

7 MR. MAURO: Would you state the recommen-
8 dations?

9 DR. JOHNSON: We recommend:

10 1. Increased Federal support be made
11 available for applied and technical dental
12 research.

13 2. The Federal Government provide a
14 grant of 50 cents per capita for the pro-
15 vision of dental services in Manitoba.

16 3. The Federal Government sponsor coordi-
17 nated studies across Canada to determine
18 whether auxiliary personnel can carry out
19 any of the procedures currently assigned
20 to dentists.

21 MR. MAURO: The next subject matter dealt
22 with in your submission, Mr. Minister, is entitled "The
23 Provision of Personnel", and in that chapter you deal
24 with the various categories and the various problems as
25 you see them. Did you wish to comment on the material
26 contained in that chapter?

27 DR. JOHNSON: Yes, Mr. Mauro. I think I
28 will comment briefly on this chapter on personnel and
29 say to the Commission, of course, that the success of any
30 program depends on well-trained and adequate and good
staff, and of course, we consider this of paramount impor-
tance. However, we have made certain observations here
largely because of the various professional groups, the



for pilot studies to determine what, if any, functions
now performed by dentists could be delegated to auxiliary
personnel.

MR. MAURO: Would you state the recommen-

dations?

DR. JOHNSON: We recommend:

1. Increased Federal support be made
available for applied and technical dental
2. The Federal Government provide a
grant of 50 cents per capita for the pro-
vision of dental services in Manitoba.
3. The Federal Government sponsor coordi-
nated studies across Canada to determine
whether auxiliary personnel can carry out
any of the procedures currently assigned
to dentists.

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5 groups will be submitting detailed submissions as to
6 their views on the personnel requirements in their parti-
7 cular areas, and also to draw to the Commission's atten-
8 tion the fact that in calling for the Manitoba Hospital
9 Survey Board Report -- the so-called Willard Report --
10 on page 2 of that study we ask for a very detailed report
11 on the personnel requirements to implement the Willard
12 Report, and as yet that second phase of that Board's
13 study has not been filed with us, but we will be very
14 pleased to make it available to the Commission as soon as
15 it is received.

16 THE CHAIRMAN: Have you any idea when it
17 will be ready?

18 DR. JOHNSON: Very shortly, I believe,
19 Mr. Chairman.

20 MR. MAURO: Mr. Minister, dealing with
21 Chapter XIV, The Role of Voluntary Health Agencies in
22 Manitoba, you list them here and deal generally with
23 their functions: would you like to make any comment on
24 this chapter?

25 DR. JOHNSON: The people of Manitoba are
26 indebted to these groups for the effective working
27 relationship that has developed between public and volun-
28 tary health agencies in the province. This relationship
29 is based on the belief that the provision of comprehensive
30 services requires a partnership between the individual,
the voluntary agency, and the government. The voluntary
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3 citizens of Manitoba.

4 I would add that without the concern of
5 the voluntary agencies and the participation of the
6 public at large that the activities of the Department of
7 Health, or of any department, would be quite meaningless
8 at the local level.

9 MR. MAURO: Your Chapter XV commencing
10 at paragraph 229 deals specifically with the subject of
11 health grants which you have covered under the various
12 headings in other chapters. Do you wish to add any
13 comment on this subject matter of health grants?
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I would add that without the concern of

the voluntary agencies and the participation of the

provincial government, the activities of the department in

relation to the voluntary agencies would be greatly diminished.

AT THE CLOSE (1961)

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at paragraph 229 deals specifically with the subject of

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headings in other chapters. Do you wish to add any

comment on this subject matter of health grants?



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4 DR. JOHNSON: In spite of the admitted
5 benefits derived from the health grants program, there
6 are several defects which we have set out in this
7 chapter and in our brief as a whole. I would refer only
8 to Item E in this chapter.

9 MR. MAURO: That is paragraph 235?

10 DR. JOHNSON: Yes.

11 "The limitation which has been placed on
12 the percentage of grant funds which can
13 be expended on continuing commitments,
14 has at times, proved embarrassing and
15 created difficulties in provincial finan-
16 cing. No increase in many of the grants
17 has occurred since 1948, while all salaries
18 have risen considerably. This has had the
19 result that where staff has been employed
20 and paid fully by grant funds at the start
21 of a programme, it becomes necessary either
22 to cancel the programme or assume provincial
23 responsibility for salaries. This has had
24 the effect in some instances of forcing
25 provincial expenditures ahead at a rate
26 that does not respect the natural rate of
27 growth or the economic circumstances of
28 the area."

29 MR. MAURO: Mr. Minister, the chapter
30 following, Chapter XVI, deals with this very important
31 aspect of health services, namely, the provision of
32 essential drugs and cost of these drugs. That chapter
33 particularly is based on the problems confronted by your

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3 Department in the Government in supplying drugs in the
4 overall health scheme. You said that public funds
5 exceeding two-and-a-quarter million dollars were expended
6 in 1960 in provision of drugs; do you anticipate an
7 increased expenditure in this field?

8 DR. JOHNSON: Yes. The rapid advances
9 and improvements in drug therapy in recent years have
10 resulted in reduced incidence and severity of certain
11 diseases and made possible the care of more patients at
12 home. For example, the community health programme has
13 resulted in a reduction in the number of hospital beds
14 required by the mentally ill and it is estimated that 30%
15 of drugs purchased by the Selkirk and Brandon Mental
16 Hospitals are used for patients under community health
17 programmes.

18 MR. MAURO: This is illustrated in Table
19 XXII?

20 DR. JOHNSON: Yes, it shows experiences
21 in that hospital and our experience in Brandon is similar.

22 THE CHAIRMAN: Those are not prescription
23 drugs?

24 DR. JOHNSON: Yes, these are prescription
25 drugs. Table XXII shows a rapid increase since 1956 in
26 the volume of drugs dispensed and in the last two years
27 this has increased despite the fact we have made consi-
28 derable savings by group purchasing through our own
29 institutions to a central purchasing bureau on a formulary
30 basis. I would also say that drugs are available to the
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3 less 15%.

4 MR. MAURO: Would you refer to Table XXIII
5 which follows paragraph 240 entitled Medicare Drug
6 Expenditures and would you describe what is illustrated
7 there?

8 DR. JOHNSON: Yes, we just wish to share
9 with the Commission information we had on hand to date
10 both giving the total amount earlier, the amount of money
11 which has been spent on drugs through various parts of
12 our Department. We just give this information which was
13 also given to the Restrictive Trade Practices Commission
14 when they met here last summer. Under Medicare in this
15 table we show the cost per prescription between the
16 hospital pharmacy and the local drugstores and the
17 difference is quite significant. There is an average
18 cost - of course, the hospital pharmacy does not pay a
19 sales tax and this includes the 40¢ Medicare fee for
20 prescriptions. That is included in the figure for the
21 hospitals. We realize hospitals enjoy discounts from
22 manufacturers and in large purchasing of large amounts of
23 drugs and so on but we think these figures should be
24 made available to the Commission at this time.

25 MR. MAURO: And you show a price range,
26 there is an average cost per prescription filled by a
27 hospital pharmacy of \$1.58 on the low end of the scale
28 and the average cost filled by a Winnipeg pharmacy is
29 \$3.07.

30 DR. JOHNSON: That is right.

MR. MAURO: And I also note that the
average cost per month under the Medicare program has

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4 advanced from \$13,000 per month in the July 1 1960 to
5 March 31 1961 period to \$22,000 in the current period.

6 DR. JOHNSON: Yes, and this just illus-
7 trates our experience in this area.

8 MR. MAURO: And on Table XXIV you have
9 carried this into your patient day base and you depict
10 there that the cost per patient day has advanced from,
11 1959 it was 96¢, 1960 it was \$1.08 and the cost per case
12 for the supply of drugs was \$9.41 in 1959 but \$10.94 in
13 1960?

14 DR. JOHNSON: That is right.

15 MR. MAURO: Would you also comment, if
16 any comment is necessary, on Table XXV which is entitled
17 "Illustration of Variation in Price Quotations by
18 Different Manufacturing Firms for the Same Quantities of
19 the Same Drugs"?

20 DR. JOHNSON: Yes, we felt we would bring
21 this to your attention. The table reveals our experience
22 last year in the prices quoted by manufacturers to the
23 Provincial Government for drugs and these were all for
24 the same type of drug.

25 THE CHAIRMAN: The same type or the same
26 drugs?

27 DR. JOHNSON: The same generic name. It
28 adds up to 491%.

29 MR. MAURO: What has the Government done
30 as to production of drugs?

31 DR. JOHNSON: The Government of Manitoba
32 has taken steps to ensure that drugs are being made
33 available at reasonable cost, however, further measures



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4 they are applied nationally.

5 MR. MAURO: And your recommendations?

6 DR. JOHNSON: The Province of Manitoba
7 therefore recommends:

8 1. Increased national services be provided
9 for evaluating the efficacy and quality
10 of drugs and the distribution of informa-
11 tion in this regard to medical practitioners,
and pharmacists.

12 2. Evaluation of the most efficient means
13 of promoting drug research in Canada.

14 3. The Food and Drugs Act and the Narco-
15 tics Control Act be amended so that, with
16 suitable controls, hospital pharmacies may
17 be permitted to fill Medicare prescriptions
18 containing narcotics and controlled drugs.

19 4. Any group purchasing programmes
20 devised for general hospitals in the
Province be deemed eligible for exemption
21 from sales tax.

22 5. Any extension of health insurance
23 programmes be designed to include coverage
24 for drugs outside of hospitals with an
appropriate deterrent factor.

25 6. That many of the above recommendations
26 could best be implemented through the
27 creation of a National Drug Board for Canada.

28 MR. MAURO: Now, the subsequent chapter,
29 Chapter XVII entitled "Manitoba Hospital Survey Board",
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3 I believe, Mr. Minister, that this material is fully
4 contained in Appendix D, the report of the Manitoba
5 Hospital Survey Board commonly referred to as the Willard
6 Report?

7 DR. JOHNSON: That is true.

8 MR. MAURO: Is there any additional
9 comment you wish to make?

10 DR. JOHNSON: No. We are very pleased
11 with the reception which the report of the Manitoba
12 Hospital Survey Board has received in the Province of
13 Manitoba. It is a very detailed and exhaustive study.
14 The Board was chaired by Dr. Willard, a former director
15 of the National Department of Health and Welfare and now
16 Deputy Minister of Health and Welfare for Canada and Dr.
17 J.A. Thompson, a former professor of medicine in our
18 province and Mr. McNabb, the hospital administrator.
19 During this study Dr. Willard involved the local communi-
20 ties to a very high degree and gave us what we considered
21 an excellent blueprint for the future in Manitoba. We
22 hope this will give us a Manitoba pattern to follow for
23 the next several years.

24 MR. MAURO: The next chapter in your
25 statement, Mr. Minister, is "The Role of the Social
26 Allowances Act in the Provision of Alternative Care,
27 Medical Care and Medical Services" and I know the
28 Commission is particularly interested in the experience
29 of the Province of Manitoba. As stated this morning by
30 the Premier the Province of Manitoba has a philosophic
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6 DR. JOHNSON: The Government of Manitoba
7 has in this submission, pointed out what programmes and
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9 the future. As previously stated the prime philosophy
10 of this Government has been to meet need and we feel that
11 the Commission should be aware of the measures we have
12 taken in Manitoba in co-operation with the Federal Govern-
13 ment to implement this philosophy. The Social Allowances
14 Act has been the instrument by which we have implemented
15 an alternative care programme primarily aimed at our aged
16 and infirm.

17 The Social Allowances Act of 1959 permits
18 the Government along with municipalities to take such
19 measures as are necessary so that no one, because of age
20 or physical or mental incapacity, shall be without the
21 basic necessities of life. These basic necessities are
22 defined as food, clothing, shelter and such goods or
23 services as are essential to the health and well-being
24 of the person.

25 The Federal authorities agreed, under the
26 terms of the Unemployment Assistance Act, to share in
27 the costs of providing these basic necessities except
28 for medical, health and administrative cost. Their agree-
29 ment to share in the costs of food, clothing and shelter
30 was based on the principle that we were determining the
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3 amplification. The Social Allowances Act is concerned
4 with people who lack the basic "necessities". People
5 can have a fairly substantial income or "means" and
6 still lack basic necessities. For example, an arthritic
7 widow age 73, has an income of \$55.00 per month old age
8 security. If the Social Allowance Programme had been
9 based on a means test, with a ceiling of \$840.000 per
10 year for a single person, her pension would have been
11 supplemented by a flat grant of \$15.00 per month. However,
12 under the "needs" test, we have a scale of costs of basic
13 necessities estimating her requirements for food, shelter,
14 clothing and personal expenses at \$63.00 per month. In
15 addition, she will require the regular services of a
16 visiting nurse at \$10.00 per month, the regular services
17 of a doctor and whatever medication he prescribes.
18 Therefore, she would be given \$8.00 per month, cash,
19 visiting nursing services paid and a Medicare card to
20 cover whatever health services are required. In other
21 words, under the Social Allowances Act, this woman's need,
22 in cash terms of \$18.00 per month plus the cost of Medi-
care services over and above her \$55.00 per month pension,
were met.

23 The policy of meeting need through this
24 Act is more effective and economical than a policy of
25 flat grant supplemental payments to the aged on a means
26 test basis. It provides alternative and preventive
27 measures of care to the elderly, frail, sick or handi-
28 capped who might otherwise stay in acute hospital care
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7 by his municipality. Prior to July 1st, 1958, when
8 municipalities were responsible for the costs of indigent
9 patients in hospital there was no incentive on them to
10 move chronic, frail, elderly, or senile patients out of
11 hospitals and into these institutions. At the same time
12 many frail, elderly, slightly senile, disoriented, often
13 just homeless, old people were placed in these institu-
14 tions by their relatives or their municipalities. Little
15 consideration or concern was given this problem by Provin-
16 cial authorities.

17 The City of Winnipeg Health Department
18 licensed the Homes in Winnipeg. Medical care was given
19 by the City to its residents, but no similar care was
20 available to non-residents. This resulted in individuals
21 with a diversity of medical care problems gravitating to
22 facilities without prior assessment and the frail,
23 elderly, the sick frail elderly, the infirm, the sick
24 infirm, the plain sick and the well were under one roof.

25 To meet this situation a Division of Alter-
26 native Care and Housing was formed to give detailed study
27 to all elements in our alternative care institutions and
28 to act as the licencing and rate setting authority. Our
29 studies, based on individual medical assessment, showed
30 that 2/3 of the occupants of these facilities were ambu-
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8 mately \$2 million, 2,000 of the 3,100 people in these
9 homes. In each case individual assessment and placement
10 on a needs basis has been carried out. In addition to
11 this support to aged and infirm in the institutions
12 mentioned, approximately 250 of the 400 cases on Home
13 Care in Manitoba are supported under this legislation.
14 The Victorian Order of Nurses and the homemaker services
15 of the Family Bureau have made their resources available.

16 Government's role is to meet need and
17 this has been our philosophy in providing medical care
18 under our Welfare programme. Medicare was instituted to
19 bring essential health care to those in need. In order
20 to preserve the traditional contribution of the profes-
21 sional groups the Provincial Government sought and
22 achieved a joint approach to this problem. As a result
23 pre-paid services were made available for medical care,
24 dental care, essential drugs and the provision of glasses.
25 The Manitoba Medical Service was our agent for the provi-
26 sion of medical care and the issuance of a comprehensive
27 care card. This card presented to a medical doctor,
28 druggist, dentist or optometrist or optician gives the
29 patient the right to these services. Chiropractic care
30 is provided for on approval by the Director of Welfare.

No matter what arrangements are made for
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required a form of infirmity care - minimal nursing care - and 10% of this latter group would qualify for care under the Hospital Plan.

With The Social Allowances Act as the instrument, we are today supporting at a cost of approximately \$2 million, 2,000 of the 3,100 people in these homes. In each case individual assessment and placement on a needs basis has been carried out. In addition to this support to aged and infirm in the institutions mentioned, approximately 250 of the 400 cases on home care in Manitoba are supported under this legislation. The Victorian Order of Nurses and the homemaker services of the Family Bureau have made their resources available. Government's role is to meet need and

this has been our philosophy in providing medical care under our Welfare programme. Medicare was instituted to bring essential health care to those in need. In order to preserve the traditional contribution of the professional groups the Provincial Government sought and achieved a joint approach to this problem. As a result pre-paid services were made available for medical care, dental care, essential drugs and the provision of glasses. The Manitoba Medical Service was our agent for the provision of medical care and the issuance of a comprehensive care card. This card presented to a medical doctor, druggist, dentist or optometrist or optician gives the patient the right to these services. Chiropractic care is provided for on approval by the Director of Welfare. Medical care now or in the future, one thing is certain,



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4 that the very expensive diagnostic aids which yearly are
5 coming into being at very great cost, necessitate that
6 these facilities be centralized at the teaching hospitals,
7 and it is to these hospitals that indigent and non-
8 indigent must now turn with more frequency. The problem
9 is complex. Final arrangements must await the findings
10 of the commission on teaching.

11 In providing dental care for recipients
12 of Medicare, the Province received the co-operation of
13 the dental profession. The fee schedule agreed upon
14 represents approximately 70% of the regular fee. The
15 dental profession found that due to higher technical fees
16 it was necessary to charge a flat fee of \$85.00 for
17 dentures. The Manitoba dental profession in addition to
18 their private practices render the following services to
19 the public. They participate in Medicare as outlined;
20 they operate a Denture Clinic where anyone, without a
21 means test, can come for denture service - upper and
22 lower dentures are provided at a cost of \$85.00; they
23 participate in our public health programme by rendering
24 dental care through our mobile clinics; they offer
25 services to dental indigents at our teaching hospitals;
26 they offer service at the Dental College.

27 Satisfactory arrangements have been made
28 with the Opticians Guild and Manitoba Optometric Society
29 with respect to the provision of ophthalmic services
30 provided under the Medicare programme. The Province is
most grateful to these groups for their willingness to
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The Manitoba Pharmaceutical Association



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4 through Medicare. Dr. M. Nickerson, the Professor of
5 Pharmacology at the University of Manitoba acted as a
6 consultant in the preparation of a pamphlet of the essen-
7 tial drugs, where both trade and generic names have been
8 included and the drugs classified for easy reference.
9 This formulary was approved by the medical profession
10 and the Pharmaceutical Association and forwarded to every
11 pharmacist and medical doctor in the Province. The Pharma-
12 ceutical Association have given a 15% reduction in the
13 cost of drugs under this programme.

14 The foregoing detail was presented to give
15 some indication of the philosophy and operation behind
16 Medicare. We trust that this will prove helpful in your
17 consideration of pre-paid comprehensive health care.

18 MR. MAURO: And you have a recommendation
19 generally?

20 DR. JOHNSON: Yes, generally we feel the
21 costs of providing the basic necessities of life including
22 essential health care be shareable costs under the Unem-
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TORONTO, ONTARIO

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4 MR. MAURO: Is there any other information
5 that you wish to submit, Dr. Johnson?

6 DR. JOHNSON: The appendices, Mr. Chairman,
7 are contained in the material here. This is a copy of
8 the formulary which was distributed. There is a copy of
9 a pamphlet given to every recipient of Medicare. I
10 might point out that in coming to our arrangements with
11 the medical profession, Mr. Commissioner, we felt that
12 we must go at this slowly, because we didn't know the
13 impact of a program of comprehensive medical care on
14 the training of future doctors, and as a Government we
15 felt we had the responsibility of ensuring that we had
16 adequately trained doctors in the future. So, by mutual
17 agreement between the university authorities, and the
18 profession and the Government, the initial step of Medi-
19 care was to purchase that portion by way of a premium
20 which would pay for house and office calls, and the
21 profession agreed to treat the group in hospitals free
22 of charge until the Teaching Commission reported. I
23 hope to have this report in a week or two, and we will
24 be glad to make that report available to the Commission.

25 MR. MAURO: Thank you Mr. Minister. I
26 would appreciate it if you would answer the questions of
27 the Commission and of my learned friend.

28 THE CHAIRMAN: Dr. Johnson, in your
29 reference to the very remarkable reduction in the number
30 of beds needed for tuberculosis, you gave us the figures,
does that represent a decrease in the incidence of infec-
tion, or is it related to a shorter term hospitalization?

DR. JOHNSON: Well, this is an absolute



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4 reduction in both the incidence of tuberculosis and the
5 results of modern therapy. I think the active program
6 conducted in the province over the years is one of the
7 very wonderful stories in medicine, as you can see from
8 Table V in this section that the incidence, the tuberculin
9 survey which we are now doing in respect of mass x-rays
10 shows a decrease in the number of positives since the
11 old days, and this has been caused, there has been as
12 much active case findings, the Hospital Commission x-rayed
13 every person in the hospital, the surveys carried out
14 throughout the province, in addition to more modern drug
15 therapy, as we point out here.

16 THE CHAIRMAN: That has resulted in a
17 much shorter stay?

18 DR. JOHNSON: A much shorter stay and cure.
19 We have taken over in the last few years, Mr. Commissioner,
20 550 beds for the care of chronic tuberculosis in this
21 province, in three years.

22 COMMISSIONER GIRARD: Mr. Minister, on
23 page 9 you state that in regard to the health units, you
24 point out that the cost of supporting a hospital bed for
25 one year is the same as the cost of acquiring the
26 services of a visiting nurse and supplying her with a
27 car. Therefore, you go on to say that 50 such nurses
28 would allow the launching of a province-wide visiting
29 nurse service. If you did this would you use the
30 services of the public health nurses in the Department
of Health, or would you use the services of voluntary
visiting nurses' agencies?

DR. JOHNSON: Well, in answer to that

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4 question, when I say that we would free some of the
5 general beds, I really mean we would prevent them being
6 built in the future. We have the Victorian Order of
7 Nurses in Manitoba, who have been very anxious to expand
8 into this area, and we are very anxious to promote it.
9 We feel that they are in the larger sense at present,
10 but we would like to tackle this in three ways. Not only
11 to utilize the services of the V.O.N. when available to
12 those cases who are placed under our welfare program of
13 home care, who need very minimum medical services; we
14 would like to use the V.O.N., and also public health
15 nurses through our hospital programs. We feel that the
16 present restriction, not allowing nurses, the Federal
17 Government at present under the Hospital Insurance Plan
18 shares in the cost of hospital-based nurses only as long
19 as they are in the hospital. We would think it would be
20 very good sense, for instance to allow a teaching hospital
21 with a thousand beds to have an in-care program for 200
22 people, where the nurse could go out into the community.
23 Here we think is where we could use especially the
24 voluntary nurses' agencies to cover this.

25 Also to supplement in-hospital bed care
26 program which has proven very valuable in this province.
27 The health unit personnel are anxious to get into more
28 home nursing, to support the local practitioners in the
29 area, so we would use both voluntary and public health
30 nursing personnel to expand in this area.

COMMISSIONER BALTZAN: Mr. Minister,
referring to page 48, if one were to cursorily take a
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4 than ten times as much use, or as much cost of medication,
5 or something to that effect. The point that I want to
6 make is that there is definitely an increase in the
7 amount of cost for drugs, and the use of drugs?

8 DR. JOHNSON: Would you repeat that
9 question sir?

10 COMMISSIONER BALTZAN: Is there a definite
11 increase in the amount of drugs and the cost of drugs
12 for the population?

13 DR. JOHNSON: I think it is largely under
14 the Hospital Plan that you are referring to sir. The
15 usage is probably the biggest factor in this province,
16 that the large number of out-patient procedures, which
17 we call Insured Services under our Plan now, to leave
18 acute beds, these people have drugs available on an out-
19 patient basis, and I would say newer and better drugs
20 account for part of it, and I think these are the two
21 reasons for the increase. More people are using them
22 each year.

23 COMMISSIONER BALTZAN: In other words,
24 there are very definite benefits, especially in relation
25 to the tuberculosis and the mental cases as a result of
26 this?

27 DR. JOHNSON: Oh, yes.

28 COMMISSIONER BALTZAN: Are there any other
29 noticeable benefits, say in relation to less hospital
30 utilization and more people rehabilitated? Do your
studies show that the consumption of these drugs, and
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6 DR. JOHNSON: It certainly has, especially
7 in the area of mental illness.

8 COMMISSIONER BALTZAN: In other words,
9 we cannot say that we are becoming purely and simply a
10 nation that has become a group of pill swallowers per se?

11 DR. JOHNSON: No sir. We don't want to
12 pre-judge the drug industry, but we certainly do feel
13 that the cost of drugs to the people of Manitoba, if
14 there is any way of lowering that cost, we are going to
15 keep more and more people out of hospital. And in our
16 mental health programs, by giving patients enough pills
17 to use at home, we have reduced our admission rates in
18 our mental health hospitals by 20%.

19 COMMISSIONER McCUTCHEON: Have you had an
20 overall saving?

21 DR. JOHNSON: Yes, we passed in the
22 Estimates in this House, two years ago --- we haven't
23 proceeded yet, and the picture looks brighter every year.

24 COMMISSIONER BALTZAN: Just one point of
25 explanation. On page 5, where you refer to a certain
26 assistance in the nature of personnel, number 8, the last
27 portion of paragraph 8 on page 5: "After one year's
28 service, bursaries are offered to nurses for a degree in
29 public health nursing". Is that open on a competitive
30 basis, or is it open to anyone who wishes to apply?

DR. JOHNSON: Just as long as it is recom-
mended by the Supervisor of Nursing Services.

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3 university degree in public health nursing?

4 DR. JOHNSON: Yes sir.

5 COMMISSIONER McCUTCHEON: That applies
6 only to nurses employed by your Department though?

7 DR. JOHNSON: No, we will take applications
8 from anyone wishing to take up public health nursing.

9 COMMISSIONER BALTZAN: How many years
10 might that be?

11 DR. JOHNSON: That is a one year's course
12 in this province.

13 COMMISSIONER VAN WART: How long do they
14 have to serve in Manitoba after the course?

15 DR. JOHNSON: At least one year for each
16 year's course given.

17 COMMISSIONER BALTZAN: Mr. Minister, just
18 one other point. On page 9, in your recommendations,
19 in the sentence referring to assistance or provision for
20 diagnostic services; if that became a part of the provi-
21 sion of the health services under the hospitalization,
22 providing to all the people the diagnostic services, by
23 that I suppose you mean x-ray and laboratory?

24 DR. JOHNSON: Yes, we feel that in this
25 recommendation sir, I might say we feel that it is so
26 very important in view of the exciting things happening
27 in medicine today, with the advances in drug therapy and
28 the opportunity through local health units and local
29 health services to better preventive medicine and keep
30 people out of the hospital. Having opened the front
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7 and pilot studies, and at the local level and the support
8 of the health branch, giving us more local health nurses,
9 and by elimination of the feeling on the medical rehabili-
10 tation grant, we can bolster our regional public health
11 services to the point where we will in the long run
12 effect great economies in the expense of hospitalization,
13 and we refer here to particularly that area in this
14 section, and as you know it is not possible under the
15 present Federal Hospital Insurance and Diagnostic Act
16 to declare that and other services as insured services,
17 and this is a very big thing that we are looking at at
18 the present time. In this province we have fostered
19 laboratory and x-ray units and municipal participation,
20 and it takes a little time to get the understanding of
21 both the medical profession and others to switch to the
22 new concept that the present Act contemplates. But this
23 particular recommendation, sir, it is hard for me to
24 plead that we keep up our preventive program and get
25 into the area of community health services to a greater
26 degree.

27 COMMISSIONER BALTZAN: Mr. Minister, if
28 there was that provision under the Federal-Provincial,
29 do your studies yet show how much it would reduce the
30 load on the individual, in relation to the cost of his
31 care, say, from the medical point of view? Let us put
32 it this way, that a patient goes to a doctor and not all

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3 that the doctor gets, or the clinic gets is actually for
4 the doctor's services or the nurse's services or ancillary
5 services. A good portion of that is x-ray, laboratory,
6 and other tests. Do your studies yet show how much of
7 that service which one receives in a clinic or private
8 office, or carried over to giving this in an out-patient,
9 how much that reduces the individual's cost to himself?

10 DR. JOHNSON: I would say this sir, that
11 under present legislation you can quite probably at this
12 time in the provinces, if we were to declare laboratory
13 and x-ray facilities as insured services under the
14 Hospital Plan at the present time in which the Federal
15 authority would share 50%, you could probably reduce the
16 medical care cost 20% in lab and x-ray alone.

17 THE CHAIRMAN: Dr. Johnson, I want to go
18 back to the matter of drugs, on page 47, Table XX1. You
19 show there that under the Manitoba Hospital Services
20 Plan there was expended from public funds the sum of
21 \$1,665,000. Does the Province of Manitoba provide more
22 in the way of cost of drugs to patients than other
23 provinces?

24 DR. JOHNSON: Mr. Commissioner, I am not
25 sure what other provinces do, but all the essential drugs,
26 all drugs prescribed by the physician in hospital are
27 covered as an in-hospital service benefit. In addition
28 to that we have declared 46 procedures as out-patient
29 procedures as insured services under the Plan in order to
30 relieve it. This may be one of the reasons why this
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have exclusions. Our concept, of course, as far as the



the doctor's services or the nurse's services or ancillary services. A good portion of that is x-ray, laboratory, and other tests. Do your studies yet show how much of that service which one receives in a clinic or private

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THE CHAIRMAN: Dr. Johnson, I want to go back to the matter of drugs, on page IV, Table XXI. You show there that under the Manitoba Hospital Services Plan there was expended from public funds the sum of \$1,685,000. Does the Province of Manitoba provide more in the way of cost of drugs to patients than other provinces?

DR. JOHNSON: Mr. Commissioner, I am not sure what other provinces do, but all the essential drugs all drugs prescribed by the physician in hospital are covered as an in-hospital service benefit. In addition to that we have declared 40 procedures as out-patient procedures as insured services under the Plan in order to relieve it. This may be one of the reasons why this



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3 acute hospital goes, is that the Federal Government
4 brought in the National Insurance and Diagnostic Services
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6 individual across Canada, and we felt that our acute
7 facilities should be our premium beds that people should
8 only be in there that are acutely ill, that the public
9 by and large have a moral and legal responsibility to
10 stay in hospital only as long as necessary, and we felt
11 that some of these procedures could be carried on on an
12 out-patient basis, and I understand that we have the most
13 comprehensive out-patient coverage in Canada. I under-
14 stand Nova Scotia is the only one which has a comparable
15 coverage, but that is no doubt, sir, one of the reasons
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3 THE CHAIRMAN: You show an expenditure of
4 \$207,000 for Medicare; that is, drug cost under Medicare
5 of \$207,000: that is for approximately 20,000 people?

6 DR. JOHNSON: 20,000 people, yes sir.

7 THE CHAIRMAN: So that there is an
8 average on drugs of \$10?

9 DR. JOHNSON: Yes, over that period of
10 time.

11 THE CHAIRMAN: Yes. Now, could we, from
12 that computation, get an estimate of what the cost of
13 prescription drugs to all citizens of Manitoba for the
14 same period would be? Would it be, say, \$10 on the
15 900 some odd-thousand people?

16 DR. JOHNSON: If you take the average
17 prescription in the Winnipeg pharmacy given here and
18 the average prescription given in the rural pharmacy,
19 and realize that the Pharmaceutical Association has
20 simply taken off the 15% contribution to the program,
21 that would give you the average cost of the average
22 prescription in Manitoba today.

23 THE CHAIRMAN: We don't know the number of
24 prescriptions, of course. I am trying to get it from a
25 population basis. Could you give an estimate of what
26 the cost to the people of Manitoba of prescription drugs
27 in any one year would be?

28 DR. JOHNSON: No, I could not give that
29 offhand, but we could try and find out.

30 THE CHAIRMAN: Would it be in the neighbour-
hood of \$9,000,000 or \$10,000,000?

DR. JOHNSON: I don't know, sir, but when

THE CHAIRMAN: You show an expenditure of

\$207,000 for Medicare; that is, drug cost under Medicare

of \$207,000; that is for approximately 20,000 people?

DR. JOHNSON: 20,000 people, yes sir.

THE CHAIRMAN: So that there is an

average on drugs of \$10?

DR. JOHNSON: Yes, over that period of

THE CHAIRMAN: Yes. Now, could we, in

that computation, get an estimate of what the cost of

prescription drugs to all citizens of Manitoba for the

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the cost to the people of Manitoba of prescription drugs

in any one year would be?

DR. JOHNSON: No, I could not give that

offhand, but we could try and find out.

THE CHAIRMAN: Would it be in the neighborhood

of \$2,000,000 or \$10,000,000?



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3 I worked out Medicare for the whole population it came
4 to \$80,000,000.

5 THE CHAIRMAN: That is everything?

6 DR. JOHNSON: Everything.

7 THE CHAIRMAN: Other things besides drugs?

8 DR. JOHNSON: I would point out, we
9 thought we would give you these figures as our actual
10 experience but, of course, whether this is an average
11 group in our population is hard to say. I would imagine
12 that of this 20,000 about 1,500 are families where the
13 breadwinner of the family has gone, neglected children
and patients over the age of 65.

14 THE CHAIRMAN: You are not able to say
15 whether that figure of, say, \$10,000,000 would be a
16 reasonable figure or not for prescription drugs for
17 Manitoba?

18 DR. JOHNSON: No, I would not be prepared
19 to say.

20 THE CHAIRMAN: Are you able to estimate
21 the ratio of prescription drugs to over-the-counter
22 drugs -- the real pills -- the real supply of pills?

23 DR. JOHNSON: Would you ask that question
again, please?

24 THE CHAIRMAN: Would you be able to give
25 an estimate of the ratio of prescription drugs to drugs
26 that are sold over the counter without prescription?

27 DR. JOHNSON: No, I could not give you an
estimate.

28 THE CHAIRMAN: You accept the proposition
29 that over-the-counter drug cost is several times as high
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5 what information we have on that, but just off the cuff
6 I couldn't give it to you.

7 THE CHAIRMAN: Well, that would be very
8 helpful, Dr. Johnson, if you could.

9 DR. JOHNSON: I think we have something
10 on it.

11 THE CHAIRMAN: Give us an estimate of the
12 total drug cost in Manitoba in any one year -- that is,
13 prescription drugs -- and the cost of the over-the-counter
14 or non-prescription drugs -- let us call them "non-pres-
15 cription".

16 COMMISSIONER McCUTCHEON: In Medicare, I
17 take it you pay for all the drugs which the physician
18 prescribes?

19 DR. JOHNSON: Within the limits of the
20 formulary.

21 COMMISSIONER McCUTCHEON: What do you do about
22 something like aspirins which they can either buy them-
23 selves or they can obtain a prescription for?

24 DR. JOHNSON: Where the doctor prescribes
25 it, it is covered, as the formulary points out.

26 COMMISSIONER McCUTCHEON: And the tendency,
27 surely, with the group you are dealing with would be for
28 the doctor to prescribe aspirin for them, whereas you
29 might simply tell me to go and buy some?

30 DR. JOHNSON: That is true, but with this
group under Medicare we are saying these are the 20,000
people of the 900,000 in the province who are lacking in



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group under Medicare we are saying these are the 20,000

people of the 300,000 in the province who are lacking in



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3 essential food, clothing and shelter.

4 COMMISSIONER McCUTCHEON: The very fact
5 they are that group means they will, I would assume,
6 obtain what we call principally over-the-counter drugs
7 by prescription so that the Government will pay for them
8 rather than themselves?

9 DR. JOHNSON: Yes. We are studying this
10 particular area at the present time with the idea of
11 possibly making our formulary a little more restrictive
12 in that area.

13 COMMISSIONER STRACHAN: Mr. Minister, on
14 page 38 you have drawn attention to the severe need of
15 dental services in rural areas. Is the Government doing
16 anything to encourage the new graduates to go to these
17 rural areas of which I am aware there are at least half-a-
18 dozen or more in the province where they are urgently
19 needed, where there is no dentist or where they need
20 another? And, along with that, is there any place in the
21 local health units for dental services?

22 DR. JOHNSON: Yes. In answer to the first
23 question, as you know, the Manitoba Dental College is now
24 open, and any needy medical student or dental student can
25 apply to the Department for a bursary to assist him in
26 getting his degree. There is the E.W. Montgomery Bursary.
27 We annually spend approximately \$53,000 a year which is
28 made available in bursaries. On the recommendation of
29 the Dean we will study any student need and make up the
30 difference between his resources and what he needs per
year, and we have also sponsored these boys in the past
in colleges if they go outside the province, and we ask

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4 them to spend one year in the Province of Manitoba for
5 each year of assistance given, and if they do stay in
6 Manitoba they do not have to pay the province back in
7 cash, but they do if they decide to pursue post-graduate
8 work and go elsewhere. Also, at present we have divided
9 our province into four regions outside Greater Winnipeg,
10 and we have three post-graduate public health trained
11 dentists. We have six dentists employed in our units,
12 and also have about ten practising dentists a year in
13 mobile clinics where they can go into the more depressed
14 areas, and we aim our program mainly at children.

15 COMMISSIONER FIRESTONE: Mr. Chairman, if
16 I may turn to ask the Minister a few questions. This
17 morning, Mr. Minister, your Premier, in paragraph 45 of
18 the brief of the Government of the Province of Manitoba,
19 suggested there are about 350,000 people in Manitoba who
20 are not covered by any medical care plan including the
21 Medicare Program of your own province. If somebody in
22 this group takes sick and he cannot pay the doctor bills,
23 either because he is unemployed or is in debt, what can
24 he do to get medical care services in Manitoba?

25 DR. JOHNSON: He can do one of three
26 things: go to his family physician who over the years
27 has probably met his responsibility; or, if there is
28 greater need for more complicated examinations or surgery
29 etc., he can be referred to either one of our university
30 teaching hospitals where comprehensive health services
are made available.

31 COMMISSIONER FIRESTONE: If the man is
32 quite honest and he cannot pay, does it mean therefore
33



them to spend one year in the Province of Manitoba for each year of assistance given, and if they do stay in Manitoba they do not have to pay the province back in cash, but they do if they decide to pursue post-graduate work and go elsewhere. Also, at present we have divided our province into four regions outside Greater Winnipeg, and we have three post-graduate public health trained dentists. We have six dentists employed in our units, and also have about ten practising dentists a year in mobile clinics where they can go into the more depressed areas, and we aim our program mainly at children.

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4 that the physicians have to look after people who cannot
5 pay for the medical care services? In other words, it
6 is the family physician who bears the burden rather than
7 the community; is that correct?

8 DR. JOHNSON: Yes, it is in many instances,
9 I am sure. You must also remember that in some instances
10 the family physician is very happy to render these
11 services in some areas.

12 COMMISSIONER FIRESTONE: Well, I presume
13 the family physician being a wonderful man will do that,
14 but he cannot keep on treating patients for free; he
15 must make a living as well, and if there are 350,000
16 people not covered, many of whom are not in a position
17 to provide and pay for these services, do you think it
18 is reasonable to put a large portion of the burden on
19 the medical profession?

20 DR. JOHNSON: No, it is not.

21 COMMISSIONER FIRESTONE: Or would it be
22 more appropriate for the community to share the cost?

23 DR. JOHNSON: Yes, and our philosophy, as
24 we have stated in this brief, under Medicare, has been --
25 the Government's responsibility is, in co-operation with
26 the professional groups, to meet the needs of these
27 people, and I would say that the medical profession in
28 this province are given every co-operation in joining
29 with the Government to meet the needs of the people for
30 whom the Government must provide wholly, such as the
Medicare group.

31 COMMISSIONER FIRESTONE: Mr. Minister, you
32 are talking about the Medicare group which is about



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COMMISSIONER FIRSTONE: Mr. Minister, you

are talking about the Medicare group which is about



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4 20,000 persons. This is a very special group. It is
5 specifically defined under your legislation. However, we
6 are talking about another 350,000 people who are not
7 covered under Medicare. Is what you are saying suggestive
8 of your thinking that the Medicare Program should be
9 extended to that group, or is what you are saying that
10 you are trying to think of widening this group, perhaps
11 another 50%, say, to 30,000, as you would expand your
12 provisions and change your legislation accordingly, but
13 still, even if you doubled the number of the Medicare
14 group, there still would be something like 330,000 people,
15 and the population is growing, that would still not be
16 provided for, and there is a pretty large group which
17 your brief refers to that does not fall into the Medicare
18 group and does not fall into the group of people who are
19 in a position to pay the present level of premiums. What
20 is your thinking about taking care of the medical needs
21 of that very much larger group?

22 DR. JOHNSON: This is a difficult area.
23 This is, of course, a matter of Government policy which
24 the Premier dealt with this morning, and my thoughts are
25 simply these, that in entering Medicare, and our
26 experience to date with the 20,000 people we have
27 mentioned, we have found very many problems which have
28 resulted in a Teaching Commission to investigate the
29 teaching of medicine. We have now had our first experience
30 in the provision of drugs, and we have had the experience
of providing dental care and optical services, because
these are worked out in the Province of Manitoba with the
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5 problems of mutual concern to both, and, as the Premier
6 indicated this morning in answer to your question, sir,
7 the speed with which he would go about the Medicare group
8 depended on the resources available in the province.

9 COMMISSIONER FIRESTONE: That is a very
10 fair answer, Mr. Minister, but come back just to the
11 matter of the principle: do I understand that your views
12 are that quite apart from the Medicare group, which are
13 welfare cases, we are now talking about the medically
14 indigent people that under certain circumstances can pay
15 and under other circumstances cannot pay, but who do not
16 fall into the welfare category: would you feel that to
17 take care of the medical requirements of this particular
18 group, which is a very large group, according to the infor-
19 mation we have, that this is the responsibility of the
20 community as a whole rather than the responsibility of
21 the doctors?

22 DR. JOHNSON: I do.

23 COMMISSIONER FIRESTONE: Thank you very
24 much.

25 COMMISSIONER McCUTCHEON: Mr. Minister,
26 you are not suggesting all these 350,000 people are
27 medically indigent, are you?

28 DR. JOHNSON: I think the whole problem of
29 provision of medical care is the definition of "indigency"
30 -- where it begins and where it ends.

31 COMMISSIONER McCUTCHEON: Would you agree
32 some of them don't choose to be covered because they are
33 prepared to deal with these problems in other ways?



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4 DR. JOHNSON: That is right, and we feel,
5 as the Premier indicated this morning, that in the area
6 of total indigency, we do have a direct responsibility,
7 and in this brief we are asking for a Federal sharing in
8 this area. We also feel that above this group the
9 Province of Manitoba possibly has a lesser role to play,
10 and I think the Premier has indicated this morning about
11 these easily definable groups, if you wish to call them
12 that, where you can define a group, that he prefers the
13 recommendation he made this morning to any other.

14 COMMISSIONER FIRESTONE: I take it, Mr.
15 Minister, you are in favour of the principle of universal
16 coverage to cover all the people in Manitoba -- at least,
17 make it available to them and that in cases where people
18 cannot pay the premium, even a reduced premium as
19 suggested by your Premier this morning, that there would
20 be some provision to take care of the payment: am I
21 right in this understanding?

22 DR. JOHNSON: Yes.

23 MR. MAURO: I would not like counsel to
24 be confused, Mr. Chairman. As I understand the question
25 and the material already put in evidence, those who are
26 indigent, so defined, are fully covered, and those who
27 fall into this other category, there would be a premium
28 which they would have to meet -- a basic premium
29 established within the means of the vast majority. I
30 think those are the categories, Mr. Minister, that have
been set up, and the expansion of the Social Allowances
group might be expanded to twice its present number, but
a person is either in this indigent group or in a group

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3 who can afford the plan as outlined by the Premier this
4 morning.

5 DR. JOHNSON: That is my understanding.

6 CH/dpw COMMISSIONER FIRESTONE: If we could go
7 back to the question; we distinguished between the indi-
8 gent which you call those covered under Medicare and
9 we distinguished the medically indigent and they are
10 people who under normal circumstances should be in a
11 position to pay whatever you consider a reasonable premium
12 but these people may be unable to pay for their premium
13 or whatever method you select. My question was: who
14 will take care of these people? Do you feel that the
15 burden should be left on the shoulders of the physicians
16 or become the responsibility of the community as a whole?
17 If I understood you correctly a little earlier your reply was
18 that this burden should not be carried by the doctors but
19 it was the responsibility of the community. Was I right
20 in that understanding?

21 DR. JOHNSON: Yes. I would like to make
22 my position clear on this; in the area of Medicare here
23 we are seeking a substantial contribution from the
24 profession in partnership in meeting the needs of those
25 who have nothing. The profession in Manitoba has inti-
26 mated they are willing to play a role in extending this
27 area above that of Medicare and we want to preserve this
28 additional responsibility and concern of the professional
29 groups in the Province of Manitoba. That is why we made
30 the recommendation we have.

31 COMMISSIONER FIRESTONE: May I now turn to
32 paragraph 206 of your submission which includes Table XVII.



who can afford the plan as outlined by the Premier this morning.

COMMISSIONER FIRESTONE: If we could go

back to the question; we distinguished between the indigent which you call those covered under Medicare and we distinguished the medically indigent and they are people who under normal circumstances should be in a position to pay whatever you consider a reasonable premium but these people may be unable to pay for their premium or whatever method you select. My question was: who will take care of these people? Do you feel that the burden should be left on the shoulders of the physicians or become the responsibility of the community as a whole? If I understood you correctly a little earlier your reply was that this burden should not be carried by the doctors but it was the responsibility of the community. Was I right in that understanding?

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COMMISSIONER FIRESTONE: May I now turn to

paragraph 208 of your submission which includes Table XVII



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4 This table shows a substantial increase in the number of
5 licensed practitioners in the Greater Winnipeg area over
6 the decade 1949 to 1959 from 528 to 807. I worked this
7 out and it is an increase of 53%. In the rest of the
8 province the increase in the number of physicians was
9 233 in 1949 to 256 in 1959 or by 10%. Over the same
10 period the population of Manitoba raised from 757,000 to
11 885,000 or 17%. Now, does this suggest to you that there
12 has been a significant improvement in the number of
13 physicians in the Greater Winnipeg area and their ability
14 to provide standard services to the people of the Winnipeg
15 area but there was not a corresponding improvement in the
16 position of the people living in the rural areas, the
17 rest of the province. In fact, for all we know, there
18 may have been either no improvement or very little
19 improvement. Now, if this is a fact, would you suggest
20 any plan you may have of encouraging more physicians to
21 practise in the rural areas?

22 DR. JOHNSON: Yes sir, we have made a few
23 statements in Section 210 with respect to this. From my
24 knowledge of the Province of Manitoba in travelling about
25 and meeting physicians we know that with the modern roads
26 and the advances in medical science despite everything
27 we must remember we have more of a tendency of centraliza-
28 tion in the province and of group practice and doctors
29 working together in covering a bigger area with fewer
30 doctors than in the past when there were not the same
roads and not the same facilities. This is a difficult
thing. We have made in the Province of Manitoba great
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 knowledge of the Province of Manitoba in travelling about
 and meeting physicians we know that with the modern roads
 and the advances in medical science despite everything
 we must remember we have more of a tendency of centraliza-
 tion in the province and of group practice and doctors
 working together in covering a bigger area with fewer
 doctors than in the past when there were not the same
 roads and not the same facilities. This is a difficult
 thing. We have made in the Province of Manitoba great
 advances in the outlying areas with doctors to carry out



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3 public health problems. However, we do suggest in the
4 future there is no doubt in certain areas of the province,
5 in the outlying areas, that a subsidy should be considered
6 to assist these men in the proper conduct of their prac-
7 tice.

8 COMMISSIONER FIRESTONE: Would you, there-
9 fore, be in favour of increasing the ratio of doctors in
10 rural areas in relation to the obvious improvement that
11 has already taken place in the Greater Winnipeg area?

12 DR. JOHNSON: Yes, we must remember too -
13 we touched on it here in the Greater Winnipeg area the
14 large percentage is due to the advance in medical science
15 with greater specialization.

16 COMMISSIONER FIRESTONE: Thank you, Mr.
17 Minister. May I now turn to paragraph 247 of your
18 submission where you make this statement:

19 "The Government of Manitoba has taken
20 steps to ensure that drugs are being made
21 available at reasonable cost, however,
22 further measures are necessary, many of
23 which can only be effective if they are
24 applied nationally".

25 Do I take it from the statement that the
26 Province of Manitoba would support a program that the
27 Federal Government may devise to aim at making drugs
28 available at reasonable cost to all the people of Canada?

29 DR. JOHNSON: We feel that - I would
30 answer the question this way - we feel that the cost of
drugs is becoming of concern to governments as the govern-
ments are getting more into the health and hospital fields



public health problems. However, we do suggest in the future there is no doubt in certain areas of the province, in the outlying areas, that a subsidy should be considered to assist these men in the proper conduct of their practice.

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"The Government of Manitoba has taken steps to ensure that drugs are being made available at reasonable cost, however, further measures are necessary, many of which can only be effective if they are applied nationally".

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4 which they did not previously concern themselves with.
5 By this statement we do say that within our national
6 health program, within our Department of Health activities
7 we have been encouraging group purchasing and the use of a
8 consultant to our Hospital Plan who is working with the
9 hospitals and so on. We have the associated hospitals
10 of Manitoba looking at group purchasing and groups of
11 hospitals in the rural areas. We do feel that it is
12 important to bring the cost of drugs within the reach -
13 bring them down to the general public as this will
14 encourage, for one thing, less hospitalization. There
15 is no doubt, as we pointed out in the brief, in many
16 marginal income groups doctors press to put people in the
17 hospital in order to get free drugs available. We do
18 feel from the studies made in our province that the
19 measures to lower these costs should be placed in the
20 hands of the Federal authorities. For that reason we
21 would welcome any steps which they would take to make
22 drugs more readily available to our people.

23 COMMISSIONER FIRESTONE: I take it from
24 your experience you have found that there are definite
25 possibilities of bringing drug prices to the consumer,
26 to the final user, down by appropriate measures? Has
27 that been your experience?

28 DR. JOHNSON: Yes, and we listed this - we
29 made this a content of our brief to the Restrictive
30 Trade Practices Commission last summer.

31 COMMISSIONER FIRESTONE: And you feel
32 more could be done if the Federal Government would enter
33 the field and undertake certain steps or certain programs
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4 DR. JOHNSON: We feel that through the
5 formation of a National Drug Board that such studies
6 could better be implemented.

7 THE CHAIRMAN: Have you given consideration
8 to the validity of such a Board constitutionally?

9 MR. MAURO: We may argue that later.

10 THE CHAIRMAN: I think it is important now.

11 MR. MAURO: I would not like to be talked
12 out of a job. I do not want the witness talking on
these legal points.

13 THE CHAIRMAN: I would expect him to
14 answer under legal advice. He put this forward as a
15 very straightforward proposition and it might be the
16 solution but I think we must ask the question, is it a
17 practical one in the legislative basis that we have in
18 Canada today as between Ottawa and the provinces under
the British North America Act?

19 MR. MAURO: Certainly it will be our
20 position that the validity of the Food and Drugs Act is
21 determined and the determination of - this will be the
22 nature of our submission.

23 THE CHAIRMAN: When you are talking about
24 regulating of prices through a National Drug Board ---

25 MR. MAURO: I do not think there is any
26 suggestion in our submission. It says the establishment
27 of a Board with no suggestion that the Board regulates
prices.

28 COMMISSIONER McCUTCHEON: What powers
29 would the Board have? What have you in mind?



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4 DR. JOHNSON: Certainly as a practising
5 physician in rural Manitoba for ten years I am concerned
6 about the amount of promotional work going on. This
7 information we registered with the Restrictive Trade
8 Practices Commission and a report of that I will be glad
9 to leave with the Commission. We feel that from the
10 material and research that have been done in connection
11 with the Restrictive Trade Practices Commission, the
12 study has indicated to us that some of our fears may be
13 justified. I am concerned, for instance, at the National
14 Advisory meeting under the Hospital Plan held once a year
15 in Ottawa which I attended, most provinces wondered where
16 we might turn to, the hospitals might turn to for some
17 guidance as to the efficacy of certain drugs. In our
18 hospital standards division and the Hospital Plan we may
19 be asked by the hospitals to place in their power funds
20 for some very expensive medication and we want to know
21 where we can turn to for guidance as to the efficacy of
22 that. This was all recorded with the Commission and led
23 us to say in this brief we wished to share with you some
24 of the experiences we have had in the province, what the
25 actual cost of the drugs are and that we have recorded
26 this with the Restrictive Trade Practices Commission.
27 Possibly the Federal authorities should look at the
28 establishment of measures to cover this. We do not think
29 we in the Province of Manitoba can do much about high
30 cost of drugs other than group purchasing and formularies.

THE CHAIRMAN: You made these representa-
tions to the Restrictive Trade Practices Commission?

DR. JOHNSON: Yes sir, last summer.



DR. JOHNSON: Certainly as a practising physician in rural Manitoba for ten years I am concerned about the amount of promotional work going on. This information we registered with the Restrictive Trade Practices Commission and a report of that I will be glad to leave with the Commission. We feel that from the material and research that have been done in connection with the Restrictive Trade Practices Commission, the study has indicated to us that some of our fears may be justified. I am concerned, for instance, at the National Advisory meeting under the hospital plan said once a year in Ottawa which I attended, most provinces witnessed where we might turn to, the hospitals might turn to for some guidance as to the efficacy of certain drugs. In our hospital standards division and the hospital plan we may be asked by the hospitals to place in their power funds for some very expensive medication and we want to know where we can turn to for guidance as to the efficacy of that. This was all recorded with the Commission and I told us to say in this brief we wished to share with you some of the experiences we have had in the province, what the actual cost of the drugs are and that we have recorded this with the Restrictive Trade Practices Commission. Possibly the federal authorities should look at the establishment of measures to cover that. We do not think we in the Province of Manitoba can do much about high cost of drugs other than group purchasing and formularies.

THE CHAIRMAN: You made three representations to the Restrictive Trade Practices Commission?

DR. JOHNSON: Yes sir, last summer.



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4 THE CHAIRMAN: I understand we are going
to have that available?

5 DR. JOHNSON: I will make a copy of that
6 available to the Commission.

7 COMMISSIONER FIRESTONE: Mr. Minister, if
8 I may continue, would you say that one of the functions
9 of this National Drug Board for Canada which you have
10 recommended would be to study why drug prices are so
11 high in Canada, a continued study and review?

12 DR. JOHNSON: Yes.

13 COMMISSIONER FIRESTONE: Would you say
14 that would be one of the functions of the National Drug
Board?

15 DR. JOHNSON: I think the big thing is
16 how much is this costing the people of Canada.

17 COMMISSIONER FIRESTONE: And you would
18 feel such studies should be carried on by the Board that
you have recommended?

19 DR. JOHNSON: I think we have to have some
20 central authority in Canada to which to turn in respect
21 to drugs.

22 COMMISSIONER FIRESTONE: And if such
23 studies are carried out by such a National Drug Board
24 you would expect that such studies would be made public
or the public know what the facts are?

25 DR. JOHNSON: I think this should be
26 shared with the provinces to assist us.

27 COMMISSIONER FIRESTONE: And how about
28 sharing it with the public of Canada, the people of
29 Canada, the results of such studies?
30

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to have that available?

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COMMISSIONER FIRESTONE: And how about



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4 DR. JOHNSON: I would say yes. I cannot
see any objection to that.

5 COMMISSIONER FIRESTONE: Thank you very
6 much, Mr. Minister. In paragraph 6 of your recommendations
7 which is really sub-paragraph 6 of paragraph 248 you
8 speak of the extension of health insurance programs be
9 designed to include coverage for drugs outside of hospi-
10 tals on an appropriate deterrent factor. Does this sub-
11 paragraph suggest that you are in favour of a pre-paid
12 drug plan for the Province of Manitoba in conjunction
13 with any extension of a health insurance program covering
most of the people in Manitoba?

14 DR. JOHNSON: I think we were referring
15 in this particular recommendation - we had in mind under
16 this extension - make an extension of home care as private
17 projects under the present hospital insurance agreement
18 or under the provision of more health grants under the
19 Medicare grant to extend home care at the community
20 level. Drugs should be an integral part of that coverage
21 because we have found in our health program that this
22 really results in getting people out of hospital and in
23 the provision of Medicare I think it will be essential in
the future to look at the possibility of a pre-paid drug
program because of the large cost involved.

24 COMMISSIONER FIRESTONE: Now, assuming
25 that a system of financing can be worked out and as you
26 previously said, assuming it is a practical scheme
27 because there are just so many dollars available at any
28 level of government, assuming some practical solution
29 could be developed over a period of time, speaking for
30

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3 the province and your own Department, you would be in
4 favour of the principle although the practicalities and
5 the means will have to be developed over a period of time.
6 However, in principle, you would be in favour of a pre-
7 paid drug scheme?

8 DR. JOHNSON: I would.

9 COMMISSIONER FIRESTONE: Thank you very
10 much, you have been very helpful.

11 THE CHAIRMAN: Thank you very much, Dr.
12 Johnson. I want to couple my thanks to you to include
13 Premier Roblin for the assistance we had from him this
14 morning and from the Government of Manitoba.

15 MR. MAURO: That is the case at this stage
16 for the Province of Manitoba. We, of course, reserve the
17 right to meet you again in Ottawa and to make any subse-
18 quent submissions we deem advisable in the interests of
19 this province.

20 THE CHAIRMAN: Such delightful gentlemen
21 we would be glad to see again.

22 Now, ladies and gentlemen, as you may
23 appreciate we have fallen somewhat behind in our time
24 schedule. We propose, with the consent of Manitoba
25 Medical Service to change the program this afternoon so
26 that we will now hear representations from the Faculty
27 of Medicine of the University of Manitoba if they are
28 ready to proceed.

29 --- EXHIBIT NO. 50: Brief of Faculty of Medicine,
30 University of Manitoba.

THE CHAIRMAN: Depending on the time

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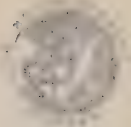
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5 Winnipeg and the Victorian Order of Nurses. The Manitoba
6 Medical Service may be able to start this afternoon but
7 I doubt it but in any event the first thing tomorrow
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9 o'clock.

10 SUBMISSION OF THE FACULTY OF MEDICINE

11 UNIVERSITY OF MANITOBA

12 Appearances: Dr. H.H. Saunderson
13 Dr. John P. Gemmell

14 DR. SAUNDERSON: Mr. Chairman and members
15 of the Commission: I should like first of all on behalf
16 of the University to welcome you to Winnipeg. I regret
17 very much that Dean Bell, Dean of our Faculty of Medicine,
18 is not able to be here in person today but he is, I
19 believe, in Ottawa preparing a brief for your Commission,
20 not only on behalf of our own Faculty but other Faculties
21 of Medicine associated with the Canadian Medical College.
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9 training of doctors after graduation, as they go into
10 practice and see the need for additional training.

11 At this time, on behalf of the Faculty of
12 Medicine, I should like to present Professor Gemmell,
13 who is an associate of Dean Bell, to make a short statement.
14 The main submission will, of course, be encompassed in
15 that of the Association.

16 PROF. GEMMELL: Mr. Chairman and Commis-
17 sioners, as Dr. Johnson pointed out, the Government of
18 the Province of Manitoba appointed a Commission on
19 Medical Education to study the effect of extension of
20 medical care plans on clinical instruction of the medical
21 student. The report of the Commission will be available
22 shortly, but until the Faculty has a chance to study
23 this report, it was felt that only a brief statement was
24 in order. As well, the Association of Canadian Medical
25 Colleges will outline to your Commission the common
26 problems of medical colleges and the University of
27 Manitoba would like to submit a formal brief at that time
28 if necessary. This present submission will emphasize
29 some aspects as they pertain to the Province of Manitoba.
30 We submit, sir, that your Commission should give the
highest priority to the provision of adequate numbers of
well-trained physicians in view of the fact that it will
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The interest of the University in matters of importance to your Commission is primarily and understandably in the training and in the research programs for medical students at the various levels, both undergraduate and graduate, and to some extent in the additional training of doctors after graduation, as they go into practice and see the need for additional training.

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3 increase in the supply of physicians.

4 The Supply of Physicians

5 With completed and projected construction
6 the physical facilities of the Faculty of Medicine is
7 able to handle 72 students in each year. Over the past
8 five years an average of 60 students have been admitted,
9 so that with increased numbers of suitable students a 20%
10 increase could result. Taking into account loss due to
11 academic and other reasons, it would be possible to
12 increase the number of graduates by an even greater percent-
13 tage if the overall quality of students improved.

14 The immediate problem is to increase the
15 number of good students entering medicine and the
16 following measures are suggested:

- 17 1. Increase the number of students
18 entering the University in general and
19 the Faculty of Medicine will share in
20 this increase.
- 21 2. Measures designed to lessen the finan-
22 cial burden of the long training period.
 - 23 a) About 75% of our students must have
24 gainful summer work to finance their educa-
25 tion. Recent years have seen considerable
26 growth in senior students working as
27 research assistants, or in hospitals as
28 summer help. A survey conducted showed
29 that 87% of our students worked in this
30 capacity between their third and fourth
years and 50% of students between their
second and third years. The usual

increase in the supply of physicians.

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6 increased availability of funds for summer
7 jobs related to medicine for medical
8 students would be helpful for both finan-
9 cial and educational reasons.

10 b) Increased availability of scholarship
11 and loan funds. From a survey conducted
12 among the 200 students it would appear
13 that the current student body is \$80,000.00
14 in debt. In many ways a combined bursary-
15 loan fund would be the best, so that each
16 dollar of loan fund could be matched by a
17 bursary dollar.

18 c) Extension of specialized funds to
19 subsidize medical students, e.g. the David
20 A. Stewart Loan Fund to promote rural
21 practice, the Armed Services plan for
22 medical officers in the services. A
23 special plea is submitted to recognize the
24 greater costs of rural students attending
25 medical school as compared to urban
26 students who can live at home. Increased
27 numbers of rural students may mean more
28 doctors for rural areas.

29 Furthermore, we would like to draw your
30 attention to the fact that due to normal attrition more
openings exist for medical students in the third year of
the course and initially, in the establishment of new
medical schools, consideration be given to establishing



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c) Extension of specialized funds to subsidize medical students, e.g. the David A. Stewart Loan Fund to promote rural practice, the Armed Services plan for medical officers in the services. A special plea is submitted to recognize the greater costs of rural students attending medical school as compared to urban students who can live at home. Increased numbers of rural students may mean more doctors for rural areas.

Furthermore, we would like to draw your attention to the fact that due to normal attrition more openings exist for medical students in the third year of the course and initially, in the establishment of new medical schools, consideration be given to establishing



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3 two-year schools.

4 The Distribution of Physicians

5 Ensuring a proper distribution of physi-
6 cians in respect of both geographic location and training,
7 is a difficult problem. Training grants to subsidize
8 education in certain specialties can prove to be a good
9 solution and has been tried with success in increasing
10 the number of psychiatrists.

11 While a minor point, it may be worthwhile
12 to improve the contact between prospective practitioners
13 and practices available. It is worth recalling that
14 attractive positions are available across the border as
15 only one small two-year medical school exists in all of
16 North and South Dakota, Montana, Wyoming and Idaho.

16 Education of Physicians

17 In common with the rest of the University,
18 the Faculty of Medicine is concerned with education and
19 research, but it is unusual in that it is intimately
20 concerned with giving patient service. To accomplish
21 these three functions of education, research and patient
22 service, we would like to introduce the idea of a medical
teaching centre.

23 The Rockefeller Foundation report on
24 "Personnel Training Requirements of the Province of
25 Manitoba" dated October, 1946, stated "This report is
26 based on the concept that the essential foundation of a
27 comprehensive health service is a properly conducted
28 medical teaching center. Such a medical teaching center
29 should be responsible not only for the training of physi-
30 cians and nurses, but also should provide approved



The Distribution of Physicians

Ensuring a proper distribution of physicians in respect of both geographic location and training is a difficult problem. Training grants to subsidize education in certain specialties can prove to be a good solution and has been tried with success in increasing the number of psychiatrists.

While a minor point, it may be worthwhile to improve the contact between prospective practitioners and practices available. It is worth recalling that attractive positions are available across the border as only one small two-year medical school exists in all of North and South Dakota, Montana, Wyoming and Idaho.

Education of Physicians

In common with the rest of the University, the Faculty of Medicine is concerned with education and research, but it is unusual in that it is intimately concerned with giving patient service. To accomplish these three functions of education, research and patient service, we would like to introduce the idea of a medical teaching centre.

The Rockefeller Foundation report on "Personnel Training Requirements of the Province of Manitoba" dated October, 1946, stated "This report is based on the concept that the essential foundation of a comprehensive health service is a properly conducted medical teaching center. Such a medical teaching center should be responsible not only for the training of physicians and nurses, but also should provide approved



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4 practice facilities for dietitians, physiotherapists,
5 etc." The Faculty of Medicine fully agrees with this
6 concept and submits that the Faculty and its teaching
7 hospitals constitute such a medical teaching centre.
8 This report mentions that "the required educational
9 reforms must necessarily take time to mature and can only
10 take place with proper co-operative efforts on the part
11 of the Government and University authorities". One of
12 the means advocated to implement this was the appointment
13 of a joint government-university planning committee. The
14 Faculty of Medicine advocates the establishment of an
15 Advisory and Planning Committee consisting of representa-
16 tives of Government, University and Manitoba Medical
17 Association and other branches of medicine.

16 Education

17 A proper academic atmosphere for clinical
18 education, where learning coincides with the gradual
19 acceptance of responsibility for patient care, is a neces-
20 sity. To provide this, the control of professional
21 services in a teaching hospital must be under the Univer-
22 sity. The obvious solution to this problem is a Univer-
23 sity hospital under University control. However, it is
24 not necessary for a University to own its own hospital as
25 shown by several leading medical schools, for example,
26 Harvard. In these instances a high standard of medical
27 education has resulted by assigning control of the medical
28 services to the medical school. Here in Manitoba, the
29 Faculty of Medicine has recommended, instead of establi-
30 shing a University hospital, that teaching units consisting
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8 cine; to patients - because of the profound conviction
9 that patient care is better in a teaching hospital and
10 our teaching hospitals represent one third of the beds
11 in the Province.

12 In order to teach clinical medicine it is
13 necessary to have patients. Any change that reduces the
14 availability of patients for teaching will lead to poorer
15 doctors. The Faculty of Medicine feels that patients
16 will voluntarily elect to attend teaching hospitals if
17 first-class technical facilities and staff, and attrac-
18 tive surroundings, are available. Ward Darley states
19 "the changing status of patients should lead to a socio-
20 economic situation in which more, perhaps most, of our
21 people would have freedom to select their health and
22 medical care from a wide spectrum of choice; further,
23 that institutions organized and operated for teaching
24 purposes, as well as those that are not, should be eli-
25 gible for such choice; and finally, that the factor of
26 competition should serve the best interests of both
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28 should be able to elect to attend the wards and clinics
29 of teaching institutions. We would like to emphasize
30 the importance of Out-Patient clinics in teaching practi-
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5 The Faculty of Medicine is well aware of
6 the high cost of medical education and to improve and
7 enlarge its facilities would be expensive. In the past
8 the bulk of clinical instruction was provided by part-
9 time clinicians with little or no financial return. Now,
10 and in the future, more full-time instructors will be
11 required and the part-time teachers should be financially
12 rewarded for their time. Unquestionably, this matter
13 will be dealt with at length in the presentation of the
14 Association of Canadian Medical Colleges.

14 The Research Function

15 Basic Research: Continued growth in basic
16 research is a necessity and more funds are required for
17 this purpose. In this expansion the University must be
18 aided in obtaining the large sums necessary for the provi-
19 sion of buildings and facilities. Furthermore, additional
20 funds should be available to the University to support
21 senior investigators to supplement the annual grant method
22 of supporting research.

23 Applied Research: The term 'clinical
24 investigation' is often given to the type of research
25 necessary to translate fundamental advances into everyday
26 usefulness. It means the development and evaluation of
27 new concepts, new tests and new treatment. It is a means
28 to provide the proper scientific atmosphere for patient
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30 With more centralized control of services there is a real
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4 the Manitoba Hospital Service Plan agreed with the
5 establishment of Clinical Investigation Units at the
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8 services are supplied by the Manitoba Hospital Services
9 Plan and funds for research come from the usual sources
10 for research funds. The highly qualified physicians in
11 charge are paid by the Hospital Services Plan, the
12 University and as senior research investigators. Such
13 functions as cardio-pulmonary units, metabolic units,
14 cardiac catheterization services, etc., come under this
15 heading. Difficulties arise in determining what is
16 research and what is patient service and the simplest
17 statement to resolve this difficulty is when the investi-
18 gator orders the test it is likely research, and if the
19 practising physicians request the test, it is patient
20 service. This means of supporting clinical investigation
21 should be extended and it is recommended as a "means of
22 encouraging a high rate of scientific development in the
23 field of medicine".

22 Operational Research: This term is
23 applied to investigation into methods of improving health
24 services. An example of such operational research is the
25 Home Care Programme centred at the Out-Patient Clinic of
26 the Winnipeg General Hospital which we feel has amply
27 justified its existence in over three years of operation.
28 While it is supported by a Public Health Research grant
29 we feel that it should be supported as a service function.
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6 extended. It appears reasonable that hospital and
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8 and operational research.

9 Patient Service

10 To carry out the educational functions of
11 the teaching hospital it is paramount to give the best
12 of patient care. Inevitably this means that teaching
13 hospitals assume the role of a 'base hospital' where
14 highly specialized services, usually of an expensive
15 nature, are concentrated. Unnecessary duplication in
16 such services should be avoided in the interest of economy
17 and to achieve this a "Scientific and Research Advisory
18 Committee to the Minister of Health" was formed. The
19 terms of reference and duties of this Committee are
20 described on page 512 of the report of the Manitoba
21 Hospital Survey Board.

22 Teaching hospitals have many duties and
23 financial responsibilities beyond other community hospi-
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25 sighted in recognizing this in the legislation for the
26 establishment of the Manitoba Hospital Services Plan.

27 The interne and residency staff of the
28 teaching hospitals should be regarded as a normal part
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Services. They represent about 15% of the doctors in Manitoba and are the major source of practitioners for our province.

SUMMARY

1. The necessity of attracting more students into the study of medicine is paramount.

2. The development and strengthening of a medical teaching centre as exemplified by the Faculty of Medicine and its teaching hospitals should receive the highest priority as the means; to provide adequate personnel with the best possible training and qualifications; to improve health services; to encourage a high rate of scientific development and medical research in the field of medicine; to act as the essential foundation of a comprehensive health service.

THE CHAIRMAN: Thank you, Dr. Gemmell. This will go forward with your other submission to Dr. MacFarlane's Committee. Dr. Gemmell, what, if anything, does the Medical College do to encourage recruitment into the College?

PROF. GEMMELL: An attempt is made by contacting high school students to encourage them into discussing this. Currently at the Faculty of Medicine we are discussing means by which we can sort of try and explain the advantages to the students already in university of the practice of medicine. It is generally obvious why a student goes into medicine; I think it is very difficult to find out why students do not go into medicine.

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3. The Faculty of Medicine should be given the highest

priority in the allocation of funds for the development

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THE CHAIRMAN: Thank you, Dr. Gemmell.

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6 sity has a decided bearing on where that student is going
7 to finish up?

8 PROF. GEMMELL: As I say, as well as
9 these talks, as you know the Canadian Medical Association
10 has attempted a program on this line.

11 THE CHAIRMAN: I was wondering about the
12 College itself, as distinct from the Medical Association?

13 DR. SAUNDERSON: I might say, Mr. Chairman,
14 that members of our staff of the Medical Faculty have in
15 fact gone out into the high schools in the periods usually
16 for the senior years of high school, to talk to students
17 and explain the benefits of a career in medicine, with
18 the hope that the students who hear that and are
19 interested in it will enter the University for their pre-
20 medical training, with the idea of going on then to the
21 Faculty of Medicine itself. A number of our people do
22 go out every year to high school groups.

23 THE CHAIRMAN: I don't know, there may be
24 another province, but I haven't heard of it, that is in
25 the happy position of having facilities for more students
26 at the present time, without any additional capital
27 outlay.

28 COMMISSIONER VAN WART: Do you have any
29 Colombo Plan students taking medicine?

30 DR. SAUNDERSON: I don't think any Colombo
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4 COMMISSIONER VAN WART: Do you have many
5 students from the United States?

6 DR. SAUNDERSON: Relatively few.

7 PROF. GEMMELL: And what few we have are
8 almost entirely from the Northern United States.

9 COMMISSIONER VAN WART: Do some of them
10 stay in Manitoba, or do they go back home?

11 PROF. GEMMELL: I think very few, a 100%
12 go back home.

13 COMMISSIONER STRACHAN: Would that number
14 be balanced by the number of Manitobans who go down to
15 medical schools in the United States?

16 PROF. GEMMELL: I would say there are very
17 few. I don't even know of a student who has gone.

18 COMMISSIONER STRACHAN: In dentistry the
19 numbers just balance, year after year.

20 DR. SAUNDERSON: We actually have, sir,
21 very few students from the United States coming to our
22 medical school, and a smaller number, and as Dr. Gemmell
23 has indicated, going into places like Minnesota, but I
24 would think on average not more than two or three a year
25 from the United States come here.

26 COMMISSIONER BALTZAN: Dr. Gemmell, page 4,
27 line 4, reads:

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11 freedoms of action and local initiative and gives the
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13 field or even, perhaps, in clinical research that you are
14 referring to.

15 PROF. GEMMELL: Dr. Baltzan, I think we
16 should have had you write this submission because I
17 approve of that. It is a joint effort between the
18 teaching hospitals and the University. The association
19 of the Faculty of Medicine with its teaching hospital
20 of some 80 years duration is one of the things we have
21 wished to maintain. The thing is that this will be a
22 joint effort, but as far as the real responsibility for
23 appointing staff to teaching -- after all, this is an
24 educational process -- is that this will be primarily
25 one of the Faculty of Medicine. We hope this sort of
26 arrangement will give the staffs considerable autonomy
27 to pursue teaching in their own way and research in their
28 own way and at the same time there will be an open hospi-
29 tal, if you like, beside it in which we hope there will
30 be contact between those two component parts of the
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31 COMMISSIONER BALTZAN: In other words,
32 your proposition is elastic and will not go to the extent,

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11 PROF. GEMMELL: I should hope that both
12 would happen. I think, certainly, we will make appoint-
13 ments from the staff of a hospital, and that is most
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15 services or facilities or teaching of a particular hospi-
16 tal to bring someone else in.

17 COMMISSIONER BALTZAN: In other words, it
18 is not altogether control or restriction?

19 PROF. GEMMELL: That is right.

20 COMMISSIONER FIRESTONE: Mr. Chairman, my
21 first question is addressed to President Saunderson.
22 From your experience in Ottawa you will recall how helpful
23 generally scholarships can be for either study or research.
24 have you given any thought to proposals for an extended
25 scholarship system for medical students attending the
26 University of Manitoba?

27 DR. SAUNDERSON: We haven't a specific
28 scheme in terms of scholarships for medical students.
29 We have some loan funds which are specific to them, but
30 from various sources -- governmental and others -- we
31 have a general scholarship and bursary program, and within
32 this general framework a number of students in the Faculty



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3 of Medicine participate, but we don't have any particular
4 scheme restricted to them for scholarships and bursaries
5 other than from the summer research.

6 COMMISSIONER FIRESTONE: As you know,
7 President Saunderson, consideration is being given to
8 extended medical care services and that will require
9 more practising physicians. As our Chairman suggested,
10 you are in a very fortunate position; you have the
11 abilities and capacities to attract more students. Could
12 some thought be given to what would be a practicable
13 proposal, not necessarily one that the University itself
14 will have to pay for out of its limited means, but one
15 that would be part and parcel of a broader or national
16 program? Could we have some proposals of what would be
17 a practical way of offering financial inducements to
18 students to take up the study of medicine at the Univer-
19 sity of Manitoba, and could we have that at a later
20 stage in writing?

21 DR. SAUNDERSON: Yes, sir.

22 COMMISSIONER FIRESTONE: That would be
23 very helpful. Dr. Gemmell, you say you have had on
24 average about 60 students admitted in medicine per year:
25 how many of these do you graduate?

26 PROF. GEMMELL: Actually, this current
27 graduate year is going to be the lowest we have had in
28 many years. The number we will graduate is 39, and this
29 is the lowest. The average from 1960 runs -- and this is
30 the last five years admissions -- it looks to my mind
some place around 45 to 50.

COMMISSIONER FIRESTONE: And do most of



of Medicine participate, but we don't have any particular scheme restricted to them for scholarships and bursaries other than from the summer research.

COMMISSIONER FIRESTONE: As you know, President Sanderson, consideration is being given to extended medical care services and that will require more practising physicians. As our Chairman suggested, you are in a very fortunate position: you have the abilities and capacities to attract more students. Could some thought be given to what would be a practicable proposal, not necessarily one that the University itself will have to pay for out of its limited means, but one that would be part and parcel of a broader or national program? Could we have some proposals of what would be a practical way of offering financial inducements to students to take up the study of medicine at the University of Manitoba, and could we have that at a later stage in writing?

COMMISSIONER FIRESTONE: That would be very helpful. Dr. Gemmell, you say you have had on average about 60 students admitted in medicine per year: how many of these do you graduate?

PROF. GEMMELL: Actually, this current graduate year is going to be the lowest we have had in many years. The number we will graduate is 39, and this is the lowest. The average from 1960 runs -- and this is the last five years admissions -- it looks to my mind some place around 45 to 50.

COMMISSIONER FIRESTONE: And do most of



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3 those graduates settle in Manitoba and remain here and
4 practise medicine in your province, out of your 40 or 50?

5 PROF. GEMMELL: I would say not more than
6 half of them will eventually settle.

7 COMMISSIONER FIRESTONE: In other words,
8 let us say you have 40 graduates and 20 remain in
9 Manitoba: you have over a thousand physicians in Manitoba,
10 and that means you are replacing physicians at the ratio
11 of about 2% of your supply. Do you think this is an
12 adequate program even to maintain your existing stock of
13 physicians? This assumes a 50-year life expectancy of
14 practice?

15 PROF. GEMMELL: I think the assumption
16 you make there is that there is no mobility among doctors
17 in Canada, and I think this is not true. I think the
18 problem of medical education should be reviewed more on a
19 national scale. The truth of the matter is that, accor-
20 ding to my calculations, that certainly if we were
21 graduating 50 students a year we could cope with the
22 replacement if they all stayed in the province. The
23 reason for people staying in the province may be entirely
24 different from the sheer numbers you graduate. I think
25 one of the things -- this is purely a personal thing in
26 dealing with students -- is that one of the reasons they
27 may not go to areas is that the facilities for practising
28 are not good in an area.

29 COMMISSIONER FIRESTONE: Dr. Gemmell, I
30 sympathize with your view you would like, and in fact,
31 Manitoba attracts graduates from other universities, and
32 I think there is a great deal of merit in interchange



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3 from other parts of Canada; this is constructive and
4 useful, and even allowing for mobility the figures that
5 have been presented to us suggest that at best you are
6 maintaining your stock and increasing it at a very slow
7 rate, and unless there is a national effort to train
8 more medical students in other provinces as well as
9 Manitoba we will not supply the additional numbers of
10 doctors which an expanded medical care program requires,
11 and therefore we cannot rely on the other provinces to
12 solve the problems of Manitoba. Part of the problem is
13 a Manitoba problem. The question, therefore, arises:
14 what can be done? You have made certain suggestions here,
15 and I was wondering whether we could ask you to give a
16 little further thought to the sort of recommendations
17 that you have in here. They are somewhat general in
18 nature and pointed in the right direction -- whether we
19 could have some more specific recommendations and concrete
20 recommendations that would fit any plans that may be
21 appropos to Manitoba, also in a broad national program?
22 It would help the Commission in advising the Canadian
23 Government on this problem. Would that be possible?
24 Could that information be made available later?

25 PROF. GEMMELL: Yes sir, it certainly
26 could.

27 COMMISSIONER FIRESTONE: Speaking for
28 the Commissioners and myself, may I suggest if you do
29 this you add one more section to it, and that section
30 would be called Financial Implications of what it is
going to cost to train these people; capital expenditures,
training expenditures, scholarships, etc. Thank you very



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THE CHAIRMAN: Thank you very much Dr.
Gemmell and Dr. Saunderson.

SUBMISSION OF THE WELFARE COUNCIL OF
GREATER WINNIPEG

Appearances: Mr. H. Spohn
Mrs. L.R. Rabson
Mr. G. Henteleff
Mrs. K.R. Trueman
Mrs. H. Murphy
Dr. G. Sisler
Miss R. Abernethy

--- EXHIBIT NO. 51: Brief of The Welfare Council of
Greater Winnipeg.

MR. SPOHN: Mr. Chairman and Commissioners,
first I would like to express on behalf of the Community
Welfare Planning Council our deep appreciation for
appearing before you and making the submission on behalf
of our Welfare Division and Recreation Division. You
will have noticed I have used the new name, as our name
prior to this was The Welfare Council of Greater Winnipeg,
until our annual meeting last Wednesday.

Mrs. Rabson will now make the submission.

MRS. RABSON: Mr. Chairman, members of the
Commission, ladies and gentlemen, the Community Welfare
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statement to the Royal Commission on Health Services.
Our submission consists of an outline of the aims, objec-
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THE CHAIRMAN: Thank you very much Dr.

Gemmell and Dr. Sanderson.

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4 and the Homemakers' Study Committee. While these concern
5 services in Metropolitan Winnipeg, and are therefore
6 chiefly of local interest, the findings and principles
7 underlying the recommendations do have application else-
8 where in Canada, and should be of interest to this
9 Commission.

10 You will note from the outline of our
11 programs that the Health Division series of discussions,
12 underway at the present time, is concerned with the role
13 of the voluntary health agency in the community. This
14 subject is being presented and discussed, in the light
15 of changing concepts in the responsibility for health
16 care of the Canadian people. The Community Welfare
17 Planning Council will make available to this Commission
18 the conclusions of this series when completed.

19 Your letter of December the 18th, Mr.
20 Chairman, requesting information on medical care and
21 hospital services for the indigent and the medically
22 indigent is receiving the attention of this group.
23 There are many health and welfare agencies within our
24 membership, including the Children's Aid and Family
25 Bureau whom you have approached who can provide data
26 concerning this question, and you will understand that
27 time will be required to process this information before
28 an answer can be given. Therefore, may we ask your
29 permission to include this information in a supplementary
30 submission?

31 When the briefs from organizations and
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5 recommended new services, and changes in existing
6 services meshing with the overall pattern of services
7 in this community.

8 We would like to ask Mrs. Murphy and Mrs.
9 Trueman to speak briefly on the reports contained in the
10 submission, if it should please the Chairman.

11 MRS. MURPHY: Mr. Chairman, members of the
12 Commission: as Chairman of the Psychiatric Services for
13 Children, our Committee has been working almost continually
14 since the welfare report was published in 1956. The main
15 emphasis has been for protection with a view to prevention
16 in psychiatric problems of children. You will see in our
17 brief before you a number of recommendations, and I
18 would like to review them with you.

19 Our first recommendation, we are happy to
20 say, has been implemented recently and was the establish-
21 ment of a special education building adjacent to or very
22 near the Children's Hospital in which is now housed our
23 Child Guidance Services for the metropolitan area of
24 Greater Winnipeg. This has come to fruition and is now
25 operating, we think, very successfully. In this building
26 are housed the classes for the physically handicapped
27 children and emotionally disturbed children, and it
28 provides an opportunity for all working with the children
29 and their problems to co-operate because of its nearness
30 to the hospital and the various agencies.

The next recommendation of our agency was
for the establishment of a pre-school clinic for children
housed in the Children's Hospital. We are happy to report



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4 They have taken this into consideration in their plans
5 in the new addition to their building.

6 The third recommendation is to provide
7 within the Children's Hospital a 30-bed ward for children
8 requiring treatment up to a period of two months. At
9 the present time they are housed in the regular wards
10 which is not satisfactory, either for the children who
11 are severely disturbed or those who are not. With these
12 again we have had the fullest co-operation from the
13 Children's Hospital Board. They have also included this
14 in their plans for expansion.

15 The next very important development that
16 we feel is necessary in our community is for the establish-
17 ment of a residential unit for severely disturbed children
18 -- those who will require treatment for a period of beyond
19 two months and up to a two-year period. These, we
20 believe, should be again situated geographically near
21 the Children's Hospital, and near the Child Guidance
22 Clinic, and it was the recommendation of my committee
23 that it would be well administered by the Children's
24 Home of Winnipeg, who have had considerable experience
25 dealing with children with similar problems. The
26 Children's Home have agreed to undertake the administra-
27 tion. Plans are well developed, and the major obstacle
28 is financial, and this is the reason for presenting it
29 to you, Mr. Chairman.
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5 necessary in our community and one would be to carry
6 beyond the age of the pre-school adolescent, that is,
7 children from infancy to 12 years. Another residential
8 unit for young people with severely disturbed problems
9 from the age of 12 to 16. We recommend that these be
10 incorporated into our psychiatric hospital either as a
11 separate area or on the adult ward.

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13 Then, we recognize that you then have to
14 have expanded facilities and more services provided for
15 children, not pre-school adolescents necessarily but
16 adolescents - pre-school adolescents and adolescents in
17 the various agencies within our community. We are now
18 dealing with children with psychiatric problems at St.
19 Agnes' School and the St. Joseph's School. It will be
20 necessary to establish these services, we believe, in
21 order to take care of what we consider are absolutely
22 essential services in our community.

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24 This, Mr. Chairman, briefly covers the
25 main recommendations of my committee, some of which are
26 well on the way to being implemented and which we ask
27 your consideration for and your assistance in bringing
28 about that implementation. As you are well aware this
29 committee was set up as an action committee after the
30 survey made by Welfare Council which pointed out very
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4 possibility of much graver and more serious problems
5 later on in life. I have with me Dr. George Sisler,
6 who is our professional consultant and any questions
7 which you may wish to ask him in this regard I am sure
8 he will be glad to answer.

9 THE CHAIRMAN: Thank you, Mrs. Murphy.

10 MRS. RABSON: Mrs. Trueman will now speak.

11 MRS. TRUEMAN: The Welfare Council has
12 recently completed a study of homemaker services in
13 this area and the conclusions of this report are being
14 made available to the Commission. In summary of that
15 report I would like to say that Homemaker Service is
16 a community service that employs mature, specially
17 trained women, often married women or widows, to assist
18 in the homes where there are children, old people,
19 acutely, chronically ill or convalescent patients or
20 disabled persons. By using this service families can
21 be kept together in their own homes. The economic advantages of such a service are immediately obvious; it is
22 less costly to provide a homemaker for a family of young
23 people during the mother's absence than to place the
24 children in foster homes. It is less expensive to
25 provide homemaking service to a convalescent patient than
26 it is to keep him in hospital. Without this service the
27 wage earner may have to take unpaid leave from work or
28 older children might have to stay home from school.

29 As a result of this study which was
30 recently conducted the Homemaker Services which
already exist in the Family Bureau in Winnipeg are to



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5 helpers will be developed who can, by working one to two
6 hours a day three times a week help aged people to stay
7 in their own homes where they wish to be rather than
8 having them placed in nursing homes. One such worker
9 can care for several households each week.

10 The community workers making home visits
11 have observed that many people over 65 cannot prepare
12 adequate meals through lack of facilities, disability
13 or ignorance of basic nutritional needs. Providing
14 nutritious and palatable meals to elderly and handicapped
15 people brings about an improvement in health and in
16 social outlook as well.

17 Our recommendations concerning meals
18 services are the luncheon clubs which are established
19 in churches or clubs or similar facilities and in addi-
20 tion a mobile meal service would be available to people
21 who are confined to their homes. Such service, a mobile
22 service, consists of a hot dinner at noon plus a cold
23 supper to be saved for the evening meal all of which is
24 available at a nominal cost.

25 In a survey or sample of cases coming to
26 the attention of welfare agencies in the month of
27 January 1961 a study of available sources of financing
28 homemaker meals and services indicated that provincial
29 and city grants would assist about 65% of needy cases,
30 18% of cases were financially able to look after them-
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Homemaker, home helper and meal services



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6 homemaker, home help and meal services be provided in
7 this community. Thank you.

8 MR. HENTELEFF: Mr. Chairman, there have
9 been distributed to the members of the Commission
10 excerpts from the study of physical education and recrea-
11 tion in Manitoba published in 1958. This deals in some
12 detail with the problems of recreation and physical
13 fitness in Manitoba in consideration of health service
14 needs. Health service in Canada to be complete must of
15 necessity include a study of physical fitness. The
16 statement as contained in the excerpts provided to you
17 emphasize the importance of physical fitness programs in
18 developing and maintaining the best possible health
19 rather than merely freedom from disease. Physical
20 fitness enables an individual to fill his place as an
21 active member of society without fatigue and with energy
22 reserves to meet unexpected stresses. Constructive
23 recreation is an important segment of the living process
24 particularly today and even more so tomorrow when so
25 much more time is available for this purpose. The
26 recommendations of the Manitoba study provide a clear
27 blueprint for the provision of adequate physical fitness
28 and recreational services in this province. Unfortunately
29 this survey to date has only in a very small part been
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5 THE CHAIRMAN: Our Secretary will arrange
6 to get additional copies.

7 THE SECRETARY: For the purpose of the
8 record this will be known as Exhibit 51A.

9
10 --- EXHIBIT NO. 51A: Report on Physical Fitness.

11 COMMISSIONER GIRARD: Mrs. Trueman, you
12 pointed out the value of homemaker services and home
13 help services and home care programs; have your services
14 been requested by the Home Care Program of the Winnipeg
15 General Hospital?

16 MRS. TRUEMAN: Yes. The Home Care people
17 representing home care worked on our committee studying
18 this problem.

19 COMMISSIONER GIRARD: Are they using the
20 same home helpers or homemakers?

21 MRS. TRUEMAN: Yes, they are major consu-
22 mers of the present supply of homemakers available from
23 the Family Bureau. This supply is taking care of only
24 about one-third of the cases that we knew in a sample
25 month.

26 COMMISSIONER GIRARD: Is it difficult to
27 get good homemakers?

28 MRS. TRUEMAN: They say it is not.
29 Apparently there are women whose children have grown up
30 and widows who quite enjoy going out to work part-time on
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3 perhaps giving them an opportunity to earn a bit of
4 income. The experience elsewhere seems to be that there
5 is almost an unlimited supply.

6 COMMISSIONER GIRARD: Are they paid by
7 the hour or on a weekly basis?

8 MRS. TRUEMAN: We have not decided what
9 the payment should be in this instance. Probably the
10 professional board will determine that but salaries
11 across Canada for homemaker services and in the European
12 countries seem to run from \$90 to \$100 a month; I would
13 say from \$20 to \$25 weekly. Where they were working one
14 or two hours a day I would expect it to be an hourly
15 charge.

16 COMMISSIONER GIRARD: Homemakers do not
17 live in the house where they work or does the home helper
18 - do home helpers ever live in?

19 MRS. TRUEMAN: Home helpers, no, but home-
20 makers are quite often full-time people who will substi-
21 tute for a mother during her absence from home and in
22 this instance, providing there is accommodation within
23 the home, the homemaker stays. Sometimes when the father
24 is home at night the homemaker can leave during that
25 period.

26 COMMISSIONER GIRARD: Thank you very much.

27 THE CHAIRMAN: How do you go about recrui-
28 ting?

29 MRS. TRUEMAN: Well, our studies have
30 indicated that the best way to get another good homemaker
is to ask a good homemaker to recommend one. The grape-
vine seems to be the best route. Church organizations are



perhaps giving them an opportunity to earn a bit of income. The experience elsewhere seems to be that there is almost an unlimited supply.

COMMISSIONER GIRARD: Are they paid by

the hour or on a weekly basis?

MRS. TRUEMAN: We have not decided what

the payment should be in this instance. Probably the professional board will determine that but salaries across Canada for homemaker services and in the European countries seem to run from \$90 to \$100 a month; I would say from \$20 to \$25 weekly. Where they were working one or two hours a day I would expect it to be an hourly

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3 helpful and I would think that through some of the other
4 home nursing services that you would hear of people who
5 would be able to do this kind of work.

6 THE CHAIRMAN: This matter of payment, is
7 the payment made by the user, that is the home where the
8 home helper or homemaker is helping out or does your
9 organization pay the homemaker?

10 MRS. TRUEMAN: Concerning the services,
11 we decided that the ability to pay should not be a
12 deterrent for deciding who should have the help. As I
13 said, I think it is 18% who are able to cover the cost
14 completely, a further percentage were subsidized mainly
15 through the Social Allowances Act of the Province of
16 Manitoba. They can pay on a fee-for-service basis if
17 they are not able to contribute to operating costs but
18 probably in assessing the Social Allowance Department
19 we would cost account the service and charge them a fee
20 for service.

21 COMMISSIONER FIRESTONE: Mr. Spohn, I
22 wonder whether there is anyone in the group that is
23 representing the Welfare Council of Greater Winnipeg
24 today that could tell us a little bit more about the
25 problems faced by people whom we call or classify as
26 the medical indigent? Is there anyone in this group who
27 could tell us a little bit more about this problem?

28 MR. SPOHN: I think that is a problem we
29 are not prepared to comment on at the moment.

30 COMMISSIONER FIRESTONE: Did I understand
from your submission that some of your agencies are
giving some consideration to this problem and we will be



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from your submission that some of your agencies are giving some consideration to this problem and we will be



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3 receiving a written submission at a later stage?

4 MRS. RABSON: That is quite correct.

5 COMMISSIONER FIRESTONE: The Children's
6 Aid Society and the Family Bureau?

7 MRS. RABSON: As well as any agency which
8 can contribute to this question we could ask them for
9 their information and we will process it and sent it on
10 to the Commission.

11 COMMISSIONER FIRESTONE: In other words,
12 we can expect a written submission on this subject?

13 MRS. RABSON: Yes.

14 COMMISSIONER FIRESTONE: In some letters
15 that have been addressed to two of the bureaus which I
16 just mentioned, it was pointed out it would be helpful
17 to us in addition to any written material that was
18 supplied to us if case workers could explain to the
19 Commissioners some of these problems, just what these
20 problems are. As you well know a memo on a piece of paper
21 and some print is all right but an individual can tell
22 a story much better. I am sure the Commissioners would
23 like to know a little bit more about the problems of
24 medical indigents, the problems they are facing, what
25 they are. We would like to draw on the firsthand expe-
26 rience of people who have had such an experience and I
27 am sure it would leave us with a better understanding.
28 Was it your intention to submit only a written submission
29 or perhaps you could have some members of these agencies
30 to appear as witnesses at a later date at a different
place.

MRS. RABSON: Well, I cannot speak to that



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4 as to who would appear. Some of the agencies may feel
5 they have sufficient information, valuable information
6 for this Commission but as far as the Community Planning
7 Council is concerned they would have to consult these
8 agencies on this. We could ask them to supply you with
9 case histories or any information you desire.

10 COMMISSIONER FIRESTONE: Would it be
11 possible for you to mention to these agencies the
12 interest of the Commission in this particular information?

13 MRS. RABSON: Yes, we could do that.

14 COMMISSIONER FIRESTONE: And if they felt
15 it was important enough to elaborate it orally we would
16 be delighted to have them appear as witnesses at another
17 place and another time convenient to them.

18 MRS. RABSON: Yes.

19 THE CHAIRMAN: May I just add to that your
20 case workers are going into homes and going in primarily
21 for medical reasons but they run into situations where
22 medical attention is indicated. If there have been
23 cases where it was impossible to obtain medical attention
24 I think we would be very interested in knowing that there
25 were such cases and the number of such cases. Obviously
26 no agency can disclose information that can be identified
27 with any particular person but I am still looking for the
28 person who has not had medical care in the large metro-
29 politan city.

30 COMMISSIONER FIRESTONE: If perhaps we
could ask a case worker to tell us the sort of problems
that people face when the doctor comes in and prescribes
a high-priced drug and they have not got the money to

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3 purchase the drug. In that case, what does a sick man
4 do? Can you pass this on as well?

5 MRS. RABSON: Yes. May I say that there
6 is a co-operation between the agencies, the medical
7 agencies, the health agencies, the welfare agencies here
8 and it is very close. In circumstances where the social
9 worker feels she can make a recommendation to her clients
10 she does this and also the Government agencies; if she
11 feels there is a Government agency that can be involved
12 she will do that.

13 THE CHAIRMAN: Have you anything further
14 to add, Mr. Spohn?

15 MR. SPOHN: No, Mr. Chairman, we have not
16 other than any questions you might like to ask. We have
17 no further submission.
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4 COMMISSIONER VAN WART: Do you feel that
5 in any plan or scheme that comes forth there is a great
6 need for the retention of a voluntary organization such
7 as yours to operate as you are operating at the present
8 time?

9 MRS. RABSON: I am sorry, but I didn't
10 quite understand your question.

11 COMMISSIONER VAN WART: If a plan or
12 scheme for medical practice comes into effect, do you
13 still feel that there is a place for your organization
14 to operate as it is operating at the present time?

15 MRS. RABSON: I believe there is. Man
16 has always found ways and means of expressing his concern
17 and his assistance to those less fortunate, and at the
18 present time it is through the voluntary agencies that
19 this concern is expressed, and we do not see in the
20 immediate future that there is any reason that this
21 should be interfered with. As a matter of fact, if this
22 sort of God-given instinct of man is interfered with in
23 any way, or stifled, it would be a step towards a deca-
24 dent society, and we would like to prevent that. We feel
25 that the voluntary organization, and we were very happy
26 to hear the Government of Manitoba support us this
27 morning, has a very vital role to play in Canadian
28 society.

29 COMMISSIONER McCUTCHEON: I take it from
30 what you say that there is more in this field than just
doctors and nurses?

MR. HENTELEFF: Positively. My own perso-
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4 which a voluntary organization of this kind plays, there
5 is not enough emphasis on confidence in agencies of this
6 kind.

7 COMMISSIONER McCUTCHEON: But that surely
8 is primarily a problem for the Community Planning Council
9 of Greater Winnipeg and the metropolitan government
10 bodies of Greater Winnipeg, and the Province of Manitoba?

11 MR. HENTELEFF: And one step further, the
12 Government of Canada itself.

13 COMMISSIONER McCUTCHEON: Yes, but firstly
14 at the Greater Winnipeg level.

15 MR. HENTELEFF: We feel it is a national
16 concern and that is why we are here today, and I just
17 speak from my own understanding that there is a sufficient
18 understanding and sufficient liaison, but sometimes using
19 the vernacular, we are looked upon as do-gooders, without
20 recognizing the validity of what has been said Mrs.
21 Rabson.

22 COMMISSIONER McCUTCHEON: I have been
23 accused of that myself, but what I am trying to make is
24 that your function, we are very happy you are here today,
25 but the function of a Planning Council as I understand it
26 is to establish this very liaison between government and
27 the voluntary organization?

28 MR. HENTELEFF: That is correct.

29 MISS DuMOULIN: There are many areas in
30 Manitoba outside Greater Winnipeg, and I think other
areas of Manitoba are not blessed with a Community
Planning Council as is Greater Winnipeg, so I would agree
with everything that has been said, and perhaps in the



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3 instances of areas where they have not these organizations
4 the role of government has to change.

5 THE CHAIRMAN: On this matter of health
6 we hear, we have heard, that it is maybe within the
7 right of an individual to be healthy or not to be healthy.
8 Sort of an indifferent view. Is that the philosophy to
9 which your group would subscribe, Mr. Henteleff, or do
10 you recognize a moral obligation on a person to be well
11 if he can?

12 MR. HENTELEFF: It is a moral obligation,
13 Mr. Chairman, for a man to be a good citizen, a good
14 Canadian citizen, and the only way he can properly fulfil
15 his function to be a good citizen is to be a healthy
16 citizen, is to be a citizen not only healthy in body but
17 in spirit, and we combine all these factors in the overall
18 term health, mental health, physical health, understanding,
19 concern. All these make up what I feel should be part
20 and parcel of a good and responsible Canadian citizen,
21 and it is not a question of, say, imposition in the
22 sense that we speak of other countries. This is imposi-
23 tion that we should welcome, and there is the difference.

24 COMMISSIONER McCUTCHEON: But the indivi-
25 dual will either act as you suggest he should act, or not.
26 I suppose to a large extent that you can educate him to
27 his moral responsibility in those fields?

28 MR. HENTELEFF: Oh, absolutely.

29 COMMISSIONER McCUTCHEON: You couldn't
30 educate him into proper nutrition, or even drinking
habits?

MR. HENTELEFF: But you can legislate



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3 funds for (a) providing facilities for the purpose of
4 providing trained personnel and I can of course keep on
5 going. To that extent we have that responsibility.
6 Whether the man wants to drink the glass of water we
7 offer him, we have to educate him to the point where he
8 will come to enjoy it, and play his part in the overall
9 community.

10 COMMISSIONER FIRESTONE: Is the point that
11 you are making that a man will not be able to exercise
12 the opportunity unless you create facilities for him to
13 be able to do so, and that this in part is also a respon-
sibility of Government?

14 MR. HENTELEFF: Oh, absolutely.

15 THE CHAIRMAN: Thank you very much, Mr.
16 Spohn and your group who have been with you. You have
17 been most helpful to us.

18 We will next hear, and this will be the
19 last today, the Victorian Order of Nurses of Canada,
20 Manitoba Division. This will be Exhibit No. 52.

21 --- EXHIBIT NO. 52: Submission of the Victorian Order
22 of Nurses for Canada on behalf of
its Branches in Manitoba.

23
24 Appearances: Mrs. Laurence Rabson
Mrs. John Abra
25 Mrs. M. Mackling
Mrs. Nelson Moore
Miss Constance Swinton

26 MISS SWINTON: Mr. Chairman, ladies and
27 gentlemen, I would like to introduce the delegates
28 representing the two branches in Manitoba. We have Mrs.
29 Rabson, President of the Winnipeg Branch. Mrs. Abra,

funds for (a) providing facilities for the purpose of providing trained personnel and I can of course keep on going. To that extent we have that responsibility.

Whether the man wants to drink the glass of water we offer him, we have to educate him to the point where he will come to enjoy it, and play his part in the overall

you are making that a man will not be able to exercise the opportunity unless you create facilities for him to be able to do so, and that this in part is also a responsibility of Government?

MR. HENRIE: Oh, absolutely.

THE CHAIRMAN: Thank you very much, Mr. Sporn and your group who have been with you. You have been most helpful to us.

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Mrs. John Ables
Mrs. M. Mackling
Mrs. Nelson Moore
Miss Constance Swinton

MISS SWINTON: Mr. Chairman, ladies and

representing the two branches in Manitoba. We have Mrs. Rabson, President of the Winnipeg Branch. Mrs. Ables,



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4 member of the Winnipeg Branch. Mrs. Mackling, Mrs. Moore,
5 President of the Brandon Branch, and myself, the Regional
6 Director for Manitoba.

7 MRS. RABSON: Mr. Chairman, members of
8 the Commission, ladies and gentlemen. It just occurred
9 to me that possibly I should change my hat to avoid a
10 little confusion in the transition.

11 THE CHAIRMAN: It is a very attractive
12 hat ---

13 MRS. RABSON: I am now speaking for the
14 Victorian Order of Nurses.

15 From the history of the development of
16 Victorian Order service in Manitoba for over sixty years,
17 the Order has attempted to meet the manifested visiting
18 nursing needs of the people. At present there are two
19 branches in Manitoba, located in Winnipeg and Brandon.
20 These two branches serve 54% of the total population of
21 the province.

22 The province of Manitoba is unique in that
23 over 50% of its population is concentrated in the metro-
24 politan Winnipeg area. This has definitely affected the
25 establishment of more branches since other urban areas
26 are small by comparison and not situated near enough
27 together to allow for combining. Portage la Prairie,
28 Flin Flon and Dauphin are three areas in which Victorian
29 Order service might be developed. If a request for
30 service were made the Victorian Order would investigate
the need and would plan to organize if the need existed
and financial support were available.

The program in the branches in Manitoba



member of the Winnipeg Branch. Mrs. Mackinnon, Mrs. Moore,
President of the Brandon Branch, and myself, the Regional
Director for Manitoba.

MRS. KASSON: Mr. Chairman, members of
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3 is essentially the provision of skilled nursing care in
4 the home on a visit basis. Over a period of years the
5 program in the Winnipeg branch has changed from one of
6 predominantly maternal and child care to one with a high
7 percentage of service to acute, convalescent and chroni-
8 cally ill patients. In order to prevent duplication of
9 services the program has been developed in co-operation
10 with health authorities which include one city health
11 department and several provincial health units as well as
12 other voluntary health agencies. Since the Brandon branch
13 has only been in operation for a few months, the material
14 contained in this submission deals mainly with the activi-
ties of the Winnipeg branch.

15 In the Winnipeg branch, by the end of
16 October 1961, an increase of 14% in visits over the
17 corresponding period in 1960 was recorded. The staff
18 was increased by three nurses and one clerical worker in
19 1961, and there are indications that a further increase
20 in nursing staff will be necessary in 1962. Sufficient
21 funds have been received to maintain current services but
22 methods of financing expanded programs would need to be
found.

23 A home care medical program for a limited
24 group of patients has been initiated at the Winnipeg
25 General Hospital. To assist in meeting medical care
26 needs in the most effective and efficient manner, more
27 organized home care programs are indicated, both for
28 patients being discharged from hospital and for those
29 who remain in their homes. The Victorian Order believes
30 it has the experience in home care to provide the nursing



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In the Winnipeg branch, by the end of October 1961, an increase of 1-1/2 in visits over the corresponding period in 1960 was recorded. The staff was increased by three nurses and one clerical worker in 1961, and there are indications that a further increase in nursing staff will be necessary in 1962. Funds have been received to maintain current services but methods of financing expanded programs would need to be found.

A home care medical program for a limited group of patients has been initiated in the Winnipeg branch. To assist in meeting medical care needs in the most effective and efficient manner, more organized home care programs are indicated, both for patients being discharged from hospital and for those who remain in their homes. The Victorian Order believes it has the experience in home care to provide the nursing



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4 service necessary in these programs and is willing to
5 assist in the planning and development of such programs.
6 The introduction of referral programs in the major hospi-
7 tals would provide continuity of nursing care for patients
8 discharged from hospital. They would also provide a
9 basis for the development of organized home care programs.

10 The recommendations and comments made in
11 the Manitoba Hospital Survey Board report concerning the
12 relationships of hospital services to alternative care
13 programs are far reaching and important in the development
14 of Victorian Order service in Manitoba. This is particu-
15 larly so in those recommendations relating to the develop-
16 ment of home care programs and to the establishment of
17 liaison programs between hospitals and health and welfare
18 agencies.

19 The comparison of the low percentage of
20 maternity and newborn care in the Winnipeg branch with
21 that of the national average suggests that there may be
22 need for development of this program in co-operation with
23 official agencies in this field.

24 A part-time occupational health counselling
25 program is provided in one industry in Winnipeg. With the
26 addition of qualified staff this service might be extended
27 to other industries.

28 The shortage of nurses with public health
29 preparation in the Winnipeg branch is one deterrent at
30 the present time to the development and extension of
services. The securing of money for bursaries and the
improvement in salary schedules should stimulate recruit-
ment. In order to maintain a high level of service in

service necessary in these programs and is willing to assist in the planning and development of such programs. The introduction of referral programs in the major hospitals would provide continuity of nursing care for patients discharged from hospital. They would also provide a basis for the development of organized home care programs. The recommendations and comments made in

the Manitoba Hospital Survey Board report concerning the relationships of hospital services to alternative care programs are far reaching and important in the development of Victorian Order service in Manitoba. This is particularly so in those recommendations relating to the development of home care programs and to the establishment of liaison programs between hospitals and health and welfare

The comparison of the low percentage of maternity and newborn care in the Winnipeg branch with that of the national average suggests that there may be need for development of this program in co-operation with official agencies in this field.

A part-time occupational health counselling program is provided in one industry in Winnipeg. With the addition of qualified staff this service might be extended to other industries.

The shortage of nurses with public health preparation in the Winnipeg branch is one deterrent at the present time to the development and extension of services. The securing of money for bursaries and the improvement in salary schedules should stimulate recruitment. In order to maintain a high level of service in



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4 present activities and to develop new programs, financial
5 support would need to be sufficient to meet the require-
6 ments for increased staff and well qualified staff. With
7 assurance of financial support the Victorian Order could
8 plan for expansion.

9 The record of the Victorian Order of
10 Nurses, Winnipeg branch, would support their conviction
11 that the voluntary agency will continue to have much to
12 contribute to the health care of Canadian citizens in
13 any future planning and we sincerely recommend that the
14 experience and knowledge of existing voluntary agencies
15 be utilized to the utmost.

16 THE CHAIRMAN: Does anyone wish to add to
17 the discussion, or comment? Are you able to offer any
18 explanation as to this transition from what used to be
19 a predominant function, looking after maternity and new-
20 born baby care, to the situation where you are now in
21 Winnipeg, where it is a minor function?

22 MRS. RABSON: I think that Mrs. Mackling
23 could answer that. It is a nursing service question.

24 MRS. MACKLING: Prior to the last ten
25 years we used to carry out the function that the provin-
26 cial health nurses now carry out in the surrounding areas
27 of Winnipeg, and since health units are located in those
28 particular areas now, we have withdrawn from that service.

29 THE CHAIRMAN: But within the metropolitan
30 area of the City of Winnipeg itself?

31 MRS. MACKLING: Well, another reason we
32 certainly feel is because our nursing care program is so
33 high in nursing care that we can, due to the pressure of



present activities and to develop new programs, financial support would need to be sufficient to meet the requirements for increased staff and well qualified staff. With assurance of financial support the Victorian Order could plan for expansion.

The record of the Victorian Order of Nurses, Winnipeg branch, would support their conviction that the voluntary agency will continue to have much to contribute to the health care of Canadian citizens in any future planning and we sincerely recommend that the experience and knowledge of existing voluntary agencies be utilized to the utmost.

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MRS. RABSON: I think that Mrs. Mackling could answer that. It is a nursing service question.

MRS. MACKLING: Prior to the last ten

years, all the health services were carried out in the surrounding areas of Winnipeg, and since health units are located in those particular areas now, we have withdrawn from that service.

THE CHAIRMAN: But within the metropolitan

area of the City of Winnipeg itself?

MRS. MACKLING: Well, another reason we certainly feel is because our nursing care program is so



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3 medical and surgical visits, we have felt that we have
4 had to cut down our instructional visits.

5 THE CHAIRMAN: The number of nurses you
6 have in Manitoba, does your recruitment to Manitoba
7 support the program here?

8 MRS. MACKLING: We have little difficulty
9 in obtaining registered nurse staff, but for other nurses
10 we have some difficulty. At the present time at our
11 University, of the 16 taking public health nursing, all
12 but one student is at the University on a Government
13 bursary, and they will return to their Government agency
14 which provides the bursary.

15 MRS. RABSON: We have two nurses in this
16 course at the moment on bursaries provided through the
17 V.O.N., one through our national office and one which we
18 obtained through the Winnipeg Foundation.

19 COMMISSIONER McCUTCHEON: On page 7 of
20 your brief you make reference to the effect that the
21 introduction of the Social Allowances Act has had. You
22 say: "In 1961 from January to the end of October there
23 were approximately 6,600 visits which were paid from
24 Government sources as compared to approximately 1,200
25 visits in 1960 for the same period"... Does that mean that
26 more and more of your work is in effect renting out your
27 services to the Government, or were you visiting the same
28 group of people prior thereto, but they were being paid
29 for by other sources?

30 MRS. RABSON: That is true.

COMMISSIONER McCUTCHEON: The latter is
true?



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4 MRS. RABSON: The Social Allowance is
5 paying for service that formerly we carried on our free
6 service. All the increase in visits is not due to this
7 legislation. There is still a steady increase in the
8 demand for our services, small in regard to those who
9 pay fully for the services, but for those in our part-
10 paid plan I could say that almost half of the increase
11 in last year came into this category. Patients that
12 cannot assume the full responsibility for full payment,
13 but are willing to assume part of the responsibility.

14 COMMISSIONER McCUTCHEON: I see that
15 your revenue from other nursing fees, including Social
16 Allowance, which probably I am assuming was largely
17 Social Allowance, was some \$2,700 in 1960. Does that
18 mean that would be five or six times that amount this
19 year?

20 MRS. RABSON: Well, the fees for service
21 in 1960, the total was 35% of our total income, and in
22 1961 it was 42% of our total income. Now, in 1960 the
23 patients paid 15%, and the Government contracts, where
24 the Government assumed the responsibility to pay us for
25 our services, was 17%, and in 1961 the patients was 19%
26 and the Government contracts increased with Social
27 Allowance to 23%.
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4 COMMISSIONER McCUTCHEON: Those Government
5 allowances include more than just social?

6 MRS. RABSON: They include the D.V.A.
7 contracts and the Home Care Program.

8 COMMISSIONER McCUTCHEON: The big increase
9 would be in the Social Allowance?

10 MRS. RABSON: Between that and the Home
11 Care Program.

12 COMMISSIONER BALTZAN: You say in Portage
13 la Prairie, Flin Flon and Dauphin are three areas in
14 which a V.O.N. program could be developed. I should like
15 to be enlightened, please, as to what would be required
16 in the way of personnel, space and transportation to set
17 up a unit like that -- what the basic organization with
18 a unit consists of?

19 MRS. RABSON: Dr. Baltzan, the responsibi-
20 lity for setting up a program is a national one, and I
21 think Miss Swinton could speak to this question.

22 MISS SWINTON: We have a tentative budget
23 for establishing a new one-nurse branch of approximately
24 \$9,000. This includes the capital expense of an auto-
25 mobile, office, and so on. It will depend a great deal
26 when we get into a community how many of these items
27 would be cash and how many would be donated. Our
28 experience when we opened the Brandon branch in September
29 last year was that we had a great many donated items
30 which, of course, reduces the capital cost. However,
\$9,000 is the budget for which we prepare to open a one-
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area of approximately, say, 5,000 to 10,000 people, and



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4 that such a population will support one nurse doing a
5 straight bedside nursing program. These cities of Portage,
6 Dauphin and Flin Flon fit into this 5,000 to 10,000
7 population range which makes them possible locations for
8 new branches.

9 COMMISSIONER BALTZAN: Do I understand you
10 right that you will require one nurse for a unit -- you
11 commence a unit with one nurse?

12 MISS SWINTON: Yes, we would open a branch
13 with one nurse and add staff as the services develop.

14 COMMISSIONER BALTZAN: How would that set
15 in with an around-the-clock service?

16 MISS SWINTON: Well, one nurse is on the
17 permanent staff and we use substitute relief service to
18 compensate for Sundays and holidays.

19 COMMISSIONER GIRARD: The V.O.N. have been
20 working with the Home Care Program in the Winnipeg
21 General Hospital, but in your report I see that you seem
22 to think that more referral programs could be set up, and
23 in Dr. Willard's report I notice there were 3,170 hospi-
24 tal beds in the Winnipeg area, so this would give room
25 for a number of referral programs in the Winnipeg area:
26 what do you think are the reasons why there are no refer-
27 ral programs set up?

28 MRS. RABSON: I think possibly this has
29 been a new concept of service in the V.O.N. in the last
30 few years, and as compared to the Home Care Programs the
referral system is a much simpler one: it involves only
nursing care. We have estimated that to provide our
major hospitals with this service in Winnipeg it would



that such a population will support one nurse doing a straight bedside nursing program. These cities of Portage Dauphin and Flin Flon fit into this 5,000 to 10,000 population range which makes them possible locations for new branches.

COMMISSIONER SALLMAN: Do I understand you right that you will require one nurse for a unit -- you commence a unit with one nurse?

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4 require the full-time duties of three qualified nurses,
5 and it would cost approximately \$5,000 a year to maintain
6 a nurse in this position; that is the cost to the V.O.N.
7 But it would be more expedient to proceed slowly and
8 possibly initiate the referral in the St. Boniface
9 Hospital which has already indicated interest in this
10 program, and this could provide a pattern to base programs
11 on within the other hospitals. Considering the bed
12 capacity of the other hospitals, possibly the nurse
13 could work part-time in each of the hospitals and the
14 cost would be distributed.

15 COMMISSIONER GIRARD: Is the scarcity of
16 qualified public health nurses one of the reasons, or
17 is it just financial?

18 MRS. RABSON: Up to the moment we have
19 had no request for this type of service. We are pushing
20 it. Mrs. Mackling is attempting to interpret the services
21 in the community to the hospital in the hope we can
22 establish it because we think it will utilize the
23 services of the Victorian Order to a greater benefit to
24 the community. Financial limitations are always present
25 with us as a voluntary agency.

26 COMMISSIONER VAN WART: May I ask one of
27 the nurses this: since the inauguration of the Hospital
28 Services Diagnostic Scheme, has the number of visits of
29 Victorian Order nurses to recently discharged patients
30 increased?

31 MRS. MACKLING: Yes. We feel this has
32 increased a great deal since the new hospital insurance
33 program.



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4 COMMISSIONER VAN WART: As I understand,
5 persons who are able to pay for the services of the
6 V.O.N. -- you make a charge for that visit; is that
7 correct?

8 MRS. MACKLING: That is right.

9 COMMISSIONER VAN WART: Have you, since
10 the inauguration of the new scheme encountered any
11 objections to the payment of this fee?

12 MRS. MACKLING: There are some patients
13 who have said that if they had stayed in the hospital
14 the drugs and dressing would be available to them free
15 of charge and they would not have to pay for the nursing
16 service. There are some patients who have also said they
17 have a prepaid medical plan and the doctor has ordered
18 this treatment, and they feel that the prepaid medical
19 plan should pay for the treatment.

20 COMMISSIONER VAN WART: In other words,
21 there is a certain amount of dissatisfaction from being
22 discharged from the hospital?

23 MRS. MACKLING: Some patients say that.

24 COMMISSIONER STRACHAN: What is considered
25 by "a request for services to the community" which you
26 mention in paragraph 2 -- "If a request for services..."?
27 What is considered a bona fide request?

28 MISS SWINTON: Mr. Chairman, we receive
29 requests from an individual citizen or groups for either
30 an extension of service or development of new programs
frequently, and our policy is that we will investigate
this request, and if we can proceed from that point we
go on further to develop it, but a request in terms of a

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7 of the agency involved, and this is sometimes where it
8 breaks down. There is, say, a group anxious to see a
9 program developed, but due to administration problems
10 and so on it never gets beyond this, and this is a problem,
11 I think. The great responsibility is in the interpreta-
12 tion -- the value of the program, and if we can do a good
13 selling job, then we can develop the program.

14 THE CHAIRMAN: Thank you very much Mrs.
15 Rabson and your associates. It has been very helpful.

16 Ladies and gentlemen, we are going to
17 adjourn until 9 o'clock tomorrow morning when we will
18 proceed with the submission of the Manitoba Medical
19 Service to be followed by the Manitoba Medical Association.

20 --- Adjournment.
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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

WINNIPEG

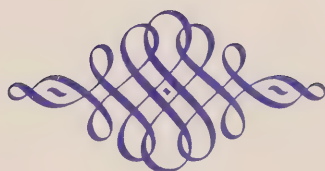
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VOLUME 13

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THE ANAESTHETIC SECTION OF THE
MANITOBA MEDICAL ASSOCIATION

3402



ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Winnipeg, Manitoba,
16th day of January, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O.J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C.L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MAJ. N. LAFRANCE

Proceedings of the hearing
held in Washington, D.C.,
day of January, 1961

CLINT JUSTICE SMITH, M. D. -- Chairman

MISS RUTH STANLEY, M. D.

DR. DAVID L. BAILEY

PROF. D. L. FLEMING

MRS. M. WALLACE MCGOUGH, D. O.

DR. ARTHUR E. VAN WART

COMMISSIONER GENERAL

MEDICAL COMMISSION

DIRECTOR OF RESEARCH

SECRETARY

MAL. A. DE RALPH



Winnipeg, Manitoba,
Tuesday, January 16th,
1962.

--- On commencing at 9 a.m.

SUBMISSION OF MANITOBA MEDICAL SERVICE

Appearances: A.S. Dewar :
Dr. D.N.C. McIntyre
Prof. W.J. Waines, B.A. M.A.
W.C. MacDonell, C.A.
Dr. F.G. Allison:
R. Murray Fisher, Q.C., LL.D.
Byron Straight, A.S.A.
J.A. Greene, C.A.
Dr. J.C. MacMaster

THE CHAIRMAN: We are now ready to hear
the submission of the Manitoba Medical Service and it
will be Exhibit No. 53.

--- EXHIBIT NO. 53: Submission of Manitoba Medical
Service.

MR. DEWAR: I appear on behalf of the
Manitoba Medical Service. In the brief that has been
filed with the Commission, Mr. Chairman, an effort has
been made consistent with reasonable brevity to picto-
rialize for the Commission and its research staff the
organization and operation of Manitoba Medical Service.
It may be there are some areas of this operation on
which you would like to have further information and if
this is the case then may I suggest with respect that
you need only ask for such information and everything
possible will be done to supply it.

I propose to read two portions of the
brief, firstly, the summary that commences at page 1 and,

Winnipeg, Manitoba,
Tuesday, January 24th,

--- On commencing at 1.30

SUBMISSION OF MANITOBA MEDICAL SERVICES

Apparances: A.S. Dewar;
Dr. D.W.C. McIntyre;
Prof. W.H. Walker, B.A., M.A.
W.C. MacDonald, M.A.
R. Murray Fisher, C.O., LL.B.
Gordon Strickland, A.S.A.

Dr. J.C. MacMaster

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4 secondly, the conclusions and recommendations commencing
5 at page 3.

6 This brief is submitted as an outline of
7 the purposes and functions of the Manitoba Medical
8 Service. It traces growth since it first began to sell
9 contracts to the public in 1944 to the present time when
10 nearly 400,000 subscribers are enrolled, with a coverage
11 which includes seven out of 10 people in the Greater
12 Winnipeg area.

13 Over 41% of the population of Manitoba is
14 covered by M.M.S. for personal health services rendered
15 by qualified medical practitioners.

16 Over 70% of the population of Greater
17 Winnipeg is covered by M.M.S.

18 M.M.S. is a voluntary non-profit corpora-
19 tion created in the public interest to bring prepaid
20 medical services to the residents of Manitoba. The
21 governing body consists of 24 members, made up of both
22 doctors and non-medical men.

23 Our members are 16 doctors and 8 lay
24 members.

25 There are six main types of groups
26 receiving service, as well as individual subscribers.
27 The groups include employer groups with collective agree-
28 ments, employer groups without collective agreements,
29 municipal groups with collective agreements, community
30 groups without collective agreements, association groups,
and social allowances groups under the auspices of the
Manitoba government.

The words or phrase "collective agreement"



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...the ... of ...

This brief is submitted as an outline of the purpose and functions of the Manitoba Medical Service. It traces growth since it first began to sell contracts to the public in 1944 to the present time when nearly 400,000 subscribers are enrolled, with a coverage which includes seven out of 10 people in the Greater Winnipeg area.

Over 81% of the population of Manitoba is covered by M.M.S., for personal health services rendered by qualified medical practitioners.

Over 70% of the population of Greater Winnipeg is covered by M.M.S. M.M.S. is a voluntary non-profit corporation created in the public interest to bring prepaid medical services to the residents of Manitoba. The governing body consists of 24 members, made up of both doctors and non-medical men.

Our members are 10 doctors and 14 laymen. There are six main types of groups receiving service, as well as individual subscribers. The groups include employer groups with collective agreements, employer groups without collective agreements, municipal groups with collective agreements, community groups without collective agreements, association groups and social allowance groups and the services of the Manitoba Government.

The words or phrase "collective agreement"



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4 in that paragraph is not related to what we ordinarily
5 regard that term in labour parlance, but it means an
6 agreement between M.M.S. and the group concerned.

7 This brief outlines the service provided
8 by its medical members and the form of their agreements.
9 It describes the fee schedule, claims processing methods,
10 and the benefits. As at September 30, 1961 there were
11 729 medical members servicing Greater Winnipeg and 245
12 beyond the Greater Winnipeg area servicing other parts
13 of Manitoba.

14 The fee schedule for doctors' services was
15 drawn up by the Manitoba Medical Association, and changes
16 in it are made only on the recommendation of the Profes-
17 sional Policy Committee of that Association.

18 At page 21 of the brief there are further
19 details about that doctors' fee schedule.

20 Operating expenses have shown a steady
21 relative reduction over the years, and in 1960 they
22 accounted for only 6.5 per cent of earned subscriptions.
23 Doctors participating in the plan do not earn 100 per
24 cent of the fee schedule; for example in 1960 under a
25 prorating plan payments to medical members were 88.7 per
26 cent of assessed claims.

27 Page 20 of the brief sets forth the
28 history of administrative expenses and payments to
29 medical members over the past five years.

30 Rates to subscribers have been increased
over the years due to increasing prorating, increasing
benefits, greater utilization of services and to the
increasing technology in the practice of medicine. The

in that paragraph is not related to what was ordinarily
regard that term in labour parlance, but it means an
agreement between M.M.S. and the group concerned.

This brief outlines the services provided
by its medical members and the form of their agreements.
It describes the fee schedule, claims processing methods,
and the benefits. As at September 30, 1981 there were
729 medical members servicing another Winnipeg and 345
beyond the Greater Winnipeg area servicing other parts
of Manitoba.

The fee schedule for doctors' services was
drawn up by the Manitoba Medical Association, and changes
in it are made only on the recommendation of the Profes-
sional Policy Committee of that Association.

At page 21 of the brief there are further
details about that doctors' fee schedule.

Operating expenses have shown a steady
relative reduction over the years, and in 1980 they
accounted for only 6.5 per cent of earned subscriptions.
Doctors participating in the plan do not earn 100 per
cent of the fee schedule; for example in 1980 under a
proportional plan payments to medical members were 86.7 per
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4 elimination of waiting periods and exemptions and the
5 full utilization of specialists makes the M.M.S. the
6 most comprehensive plan of its kind in North America and
7 we believe the Commission will find our rates to be rela-
8 tively modest.

9 M.M.S. offers a paid-in-full type programme
10 for those with incomes under \$10,000 per year.

11 Comprehensive medical care (Plan HCX) is
12 the plan preferred by most people covered, 82%.

13 The limited-service plan (H) for in-
14 hospital medical care is not popular and is difficult to
15 sell.

16 You will find the details of the service
17 provided under that plan on page D4 of the submission
18 and with respect to plan HCX you will find it outlined
19 on page D2. At this point may I direct your attention
20 to page 18 of the submission.

21 The comprehensive plan HCX is the plan
22 preferred by most of our subscribers. While we have
23 mental reservations about selling this wide benefit pro-
24 gramme indiscriminately, we find that it is demanded,
25 once the applicant decides he wants to provide coverage
26 for himself and his dependents.

27 Much the same experience has been
28 gathered by our representatives in enrolling residents
29 of the Rural Municipality of Brenda. In that community
30 1434 persons were covered by Plan HC of M.M.S. by tax
funds. The option of extra services at subscribers' expense was taken by over 80% of the 1434 to bring up the level of benefits to comprehensive HCX.

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of the Rural Municipality of Brandon. In that community

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expense was taken by over 80% of the 1434 resulting in

the level of benefits to comprehensive HX.



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4 I would add one other municipality has
5 entered in a similar manner and that is the municipality
6 of St. Francois-Xavier and in that municipality approxi-
7 mately 70% of those covered have taken what is called
8 supplementary coverage.

9 Despite the catastrophic cost coverage
10 provided by Plan H for in-hospital personal medical
11 services and the fact that the price is probably within
12 easier reach of the hard pressed, such as the aged,
13 retired and low income groups, we are not successful in
14 selling Plan H.

15 It is worthy of note perhaps, that M.M.S.
16 has proven its willingness to meet specifications where
17 national or regional accounts required a uniform programme
18 that would include Manitoba. Here again, local demand
19 has always been in evidence to supplement the out-of-
20 province programme.

21 M.M.S. offers coverage for the aged,
22 infirm and for those hitherto classified as "uninsurable".

23 Coverage for the aged is available from
24 M.M.S. on an individual basis, but the cost is likely to
25 rise, as morbidity goes along with advancing age. Group
26 coverage is continued for retirees when requested by
27 their group and at the going rate for the group.

28 We are satisfied that we continue to
29 receive the support of our member physicians.

30 From independent surveys conducted by
marketing analysts, we are certain that the present wide
range of benefits meets public demand.

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4 CONCLUSIONS AND RECOMMENDATIONS

5 Manitoba Medical Service is in a sound
6 financial position and has the administrative organization
7 necessary to expand its operations to a more universal
8 coverage of Manitoba citizens. While plans, that may be
9 designed to cover the more scattered rural population
10 of the Province, will undoubtedly involve complicated
11 administrative procedures, the resulting volume increase
12 can be handled with little additional administrative cost.

13 Some experience to date indicates that
14 rural enrollment through municipal auspices by local
15 option, or voluntarily, has the advantages of (1) designing
16 the plan to fit the needs of the area, (2) more firm and
17 less costly administrative control, (3) encouragement of
18 improved health services, (4) sound application of selec-
19 tive municipal or government subsidy where required and
20 (5) through experience rating, service at its own cost
21 to each particular area.

22 The "some experience" referred to there
23 is particularly experience in the municipalities of
24 Brenda and St. Francois-Xavier.

25 M.M.S. has developed plans for prepaid
26 medical care acceptable to both its subscribers and the
27 medical profession at a cost reasonably acceptable to all
28 income levels in the community with the possible exception
29 of the semi-indigent group. Indigents are covered by
30 government contract under the Social Allowances Medicare
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Now, the Social Allowances Medicare Pro-
gramme covers a portion of their health services only.

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rural enrollment through municipal auspices by local option, or voluntarily, has the advantages of (1) designing the service to meet the needs of the community, (2) less costly administrative control, (3) encouragement of improved health services, (4) sound application of rates to the municipal or government subsidy where required and (5) through experience rating, service at its own cost to each participating area.

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M.M.S. has developed plans for prepaid medical care acceptable to both its subscribers and the medical profession at a cost reasonably acceptable to all income levels in the community with the possible exception of the semi-indigent group. Indigents are covered by government contract under the Social Assistance Medical programme. Now, the Social Assistance Medical programme covers a portion of their health services only.



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4 I would point out the details of what is covered under
5 that contract are also contained in Exhibit D of the
6 submission.

7 Adequate care of the semi-indigent group
8 requires attention and a resulting subsidy in a form
9 which cannot properly be resolved by M.M.S. Our organiza-
10 tion however is in a better position than any other to
11 serve this group under any type of plan that may be
12 designed in the best interests of both the public and the
13 medical profession.

14 In this respect we are periodically asked
15 to provide statistical information on possible costs and
16 types of plans best suited to various income levels in
17 the community. We have no data or basic statistics upon
18 which to judge income levels or ability to pay of present
19 subscribers and such information with respect to the non-
20 member public is not available to us in an adequate form.
21 In all phases of our development we have been forced to
22 pioneer and to adjust our plans and rates on the basis of
23 our own experiments. We suggest that experimentation is
24 also necessary in this field of care for semi-indigents
25 and that any plan that might be developed should be
26 subject to continuous review in its early stages.

27 Our subscribers have indicated some concern
28 with respect to fluctuating and increasing costs of
29 medical service. Public usage of medical services
30 continues to increase and we consider it both proper and
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own level of desirable service and that the medical profes-
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3 We believe that this can best be accomplished through
4 the voluntary plans that we offer with their inherent
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6 The science of medicine progresses in an
7 orderly, regular and evolutionary manner. This advance
8 is dependent largely on the "multi-experiment" approach.
9 In our opinion, a similar pattern of development should
10 be fostered in the complex and relatively new field to
11 meet the costs of necessary, adequate and appropriate
12 health care.

13 Now, Mr. Chairman, the members of the
14 delegation that are present this morning are here for
15 the purpose of answering questions that the Commission
16 may have. May I ask that if possible the questions be
17 directed to Dr. McIntyre who is Chairman of the Board and
18 if he is unable to give you the full answer he can
19 obtain the necessary information from the other members
20 who are here.

21 THE CHAIRMAN: Thank you very much, Mr.
22 Dewar. Dr. McIntyre, in your summary on page 2 you have
23 this statement that the "elimination of waiting periods
24 and exemptions and the full utilization of specialists
25 makes the M.M.S. the most comprehensive plan in North
26 America". Now, reverting to the recommendation to the
27 submission made by Premier Roblin yesterday morning
28 which I think you heard in which he gave it as his
29 opinion that he favoured the voluntary plan and that
30 consideration might be given to using M.M.S. as the
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M.M.S. is at the moment a medical service plan. Can you

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4 see whether it would be possible to extend M.M.S. so as
5 to include dental service, drugs and other services
6 that would come within the ambit of a comprehensive
7 health service plan?

8 DR. McINTYRE: Yes, Mr. Chairman, this is
9 possible. In anticipation of these increased demands
10 we have set up a subsidiary insurance company the details
11 of which are contained in Appendix F of our brief.

12 THE CHAIRMAN: I do not want to go off on
13 a side road, Dr. McIntyre; my question is, apart from a
14 subsidiary company can you see M.M.S. as being possible
15 of expansion without the organization of separate branches,
16 separate administrative bodies?

17 DR. McINTYRE: Well, this is part of
18 M.M.S., this subsidiary company is wholly owned and that
19 is why it was set up. It is administered by the present
20 management of M.M.S.

21 THE CHAIRMAN: Is your answer then that
22 it would have to be done through a subsidiary company or
23 something of that kind?

24 DR. McINTYRE: No, my answer is that
25 M.M.S. can do it.

26 THE CHAIRMAN: Now, what about services
27 such as would be rendered by chiropractors?

28 DR. McINTYRE: This could conceivably be
29 done.

30 THE CHAIRMAN: Well, do you accept the
theory that there should be, if you are going to have a
plan to cover the Province of Manitoba then it ought to
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DR. McINTYRE: No, not necessarily, sir.
We welcome private insurance carriers in this field.

THE CHAIRMAN: Have you anything further
you would like to add in this context?

DR. McINTYRE: Sir, we do not feel that
M.M.S. should have a monopoly in this field. We do not
feel that if this scheme is voluntary on the part of the
patients that one vehicle should have a monopoly in this
field. We do feel that there should be a standard basic
contract which all carriers in this field must meet and
in some areas consideration might even be given to having
a standard premium.

THE CHAIRMAN: By standard premium would
you mean a uniform premium?

DR. McINTYRE: A uniform premium in some
areas, not a uniform premium for the whole population.

THE CHAIRMAN: You mean territorial areas
or areas of population?

DR. McINTYRE: Areas of income.

THE CHAIRMAN: Do you see that as a matter
of practical application?

DR. McINTYRE: Yes, sir.

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4 THE CHAIRMAN: Might that presuppose that
5 persons remain in fixed income areas then? I mean,
6 income in the Province of Manitoba fluctuates so much
7 from year to year.

8 DR. McINTYRE: Well, this has been done
9 in other geographic areas and has worked.

10 THE CHAIRMAN: On this matter of income,
11 is the provision in the M.M.S. contract to permit the
12 physician to charge more to those with an income of more
13 than \$10,000 used to any degree?

14 DR. McINTYRE: This is left up to the
15 individual doctor, Mr. Chairman, and it is extremely
16 difficult to establish, just private canvassing, and I
17 would think it is not too wide-spread.

18 THE CHAIRMAN: Is there any limitation on
19 this charge that may be made to the income over ten
20 thousand?

21 DR. McINTYRE: No, there is not.

22 THE CHAIRMAN: It is not even limited to
23 the fee schedule?

24 DR. McINTYRE: No sir, it is limited to
25 the doctor's conscience.

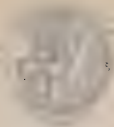
26 THE CHAIRMAN: Oh, perhaps the view that
27 the patient may take of paying as well?

28 DR. McINTYRE: Yes sir.

29 THE CHAIRMAN: I mean, the doctor cannot
30 be the only judge of the fee, can he?

DR. McINTYRE: No, that is right sir.

THE CHAIRMAN: In Section 13, page 2, you
say M.M.S. offers coverage for the aged, the infirm, and



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4 for those hitherto classified as uninsurable. I under-
5 stand that is of recent origin. When did it go into
6 effect?

7 DR. McINTYRE: I wonder if I could direct
8 that question to Dr. MacMaster?

9 DR. MacMASTER: Our cover for the aged,
10 Mr. Chairman, age limitations were removed two years ago.
11 The infirm have always been eligible for coverage. At
12 one time there was an exclusion for the specific disability
13 for one year. That was removed. The hitherto uninsurable
14 have always been covered if they can pay the subscription
15 rate.

16 THE CHAIRMAN: What do you mean by that?

17 DR. MacMASTER: Well, the word used is
18 premium. We prefer the word subscription rate sir.

19 THE CHAIRMAN: Well, I think premium will
20 be more widely understood. What you call a subscription
21 rate is in fact the premium?

22 DR. MacMASTER: Yes.

23 THE CHAIRMAN: What do you mean by the
24 word uninsurable? You put it in quotations here. It
25 must have a meaning.

26 DR. MacMASTER: Well, we have always been
27 able to provide coverage for people on a group or a non-
28 group basis. In many areas people are not eligible for
29 coverage on a non-group basis. We call these people
30 uninsurable.

THE CHAIRMAN: So the uninsurable there
does not mean uninsurable from a medical standpoint?

DR. MacMASTER: No.



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THE CHAIRMAN: So the uninsurable there does not mean uninsurable from a medical standpoint? DR. MACMASTER: No.



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4 THE CHAIRMAN: Or what we might ordinarily
5 call from the insurance standpoint?

6 DR. MacMASTER: That is right.

7 THE CHAIRMAN: Your contract; once a
8 person becomes a member, becomes eligible for benefits,
9 having been accepted, has that person the right to member-
10 ship in perpetuity, so long as he pays the premium?

11 DR. MacMASTER: Yes he has.

12 THE CHAIRMAN: Well, I find in your
13 contract that there is a provision that you can cancel
14 him out on 30 days. Isn't that a fact?

15 DR. MacMASTER: For non-payment of
16 premium?

17 THE CHAIRMAN: No, for any cause.

18 DR. MacMASTER: That section 70 has never
19 been used in my experience.

20 THE CHAIRMAN: It is on page F-6 of your
21 booklet. "The Association may at its option terminate
22 this contract if the subscription is not paid when due.
23 Either party may terminate this contract at the end of
24 any contract month by giving the other party 30 days
25 prior notice in writing to that effect".

26 DR. MacMASTER: There may be a legal
27 reason for putting that there. I don't know of any prac-
28 tical one, apart from non-payment of the fee.

29 THE CHAIRMAN: The practical one is that
30 you could throw anybody out at the end of 30 days, isn't
it?

DR. MacMASTER: I doubt if we would want
to do that.



THE CHAIRMAN: OF WHAT WE MIGHT ORDINARILY

CALL FROM THE INSURANCE STANDPOINT?

DR. MACMASTER: THAT IS RIGHT.

THE CHAIRMAN: YOUR CONTRACT; ONCE A

PERSON BECOMES A MEMBER, BECOMES ELIGIBLE FOR BENEFITS,

HAVING BEEN ACCEPTED, HAS THAT PERSON THE RIGHT TO MEMBERSHIP

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THE CHAIRMAN: WELL, I FIND IN YOUR

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THE CHAIRMAN: IT IS ON PAGE F-6 OF YOUR

BOOKLET. "THE ASSOCIATION MAY AT ITS OPTION TERMINATE

THIS CONTRACT IF THE SUBSCRIPTION IS NOT PAID WHEN DUE.

EITHER PARTY MAY TERMINATE THIS CONTRACT AT THE END OF

ANY CONTRACT MONTH BY GIVING THE OTHER PARTY 30 DAYS

PRECEDING NOTICE IN WRITING TO THAT EFFECT."

DR. MACMASTER: THERE MAY BE A LEGAL

REASON FOR PUTTING THAT THERE. I DON'T KNOW OF ANY PRACTICAL

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IT?

DR. MACMASTER: I DOUBT IF WE WOULD WANT

TO DO THAT.



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4 THE CHAIRMAN: "Quite, that is a matter of
policy?

5 DR. MacMASTER: Right.

6 THE CHAIRMAN: And you say it has not
7 been exercised?

8 DR. MacMASTER: That is right.

9 THE CHAIRMAN: But you will appreciate
10 that it vitiates the statement that the person is
entitled to maintenance of membership?

11 DR. MacMASTER: Yes, if he satisfies all
12 the conditions I think he is entitled to membership,
13 continuous membership.

14 THE CHAIRMAN: Therefore, on that basis
15 he is a member so long as you want him to be a member?

16 DR. MacMASTER: Yes.

17 THE CHAIRMAN: Do you accept the proposi-
18 tion that if there was a program that was intended to
19 cover everybody who wanted to be covered, that such a
limitation would have to go by the boards?

20 DR. MacMASTER: Well, surely this contract
21 would be redesigned in a situation like that?

22 THE CHAIRMAN: You have a member of a
23 group, and he ceases to be a member of that group; has
24 he the absolute right to continue his membership, forget-
ting for the moment this 30-day business?

25 DR. MacMASTER: He has that right.

26 THE CHAIRMAN: I would like your explana-
27 tion on paragraph 14 in page 2: "Group coverage is
28 continued for retirees when requested by their group".
29 Now, is that a condition, that the group must request it,
30

THE CHAIRMAN: Quite, that is a matter of

DR. MACMASTER: Right.

THE CHAIRMAN: And you say it has not

been exercised?

DR. MACMASTER: That is right.

THE CHAIRMAN: But you will appreciate

that it vitiates the statement that the person is

entitled to maintenance of membership?

DR. MACMASTER: Yes, if he satisfies all

the conditions I think he is entitled to membership,

continuous membership.

THE CHAIRMAN: Therefore, on that basis

he is a member so long as you want him to be a member?

DR. MACMASTER: Yes.

THE CHAIRMAN: Do you accept the proposi-

tion that if there was a program that was intended to

cover everybody who wanted to be covered, that such a

limitation would have to go by the boards?

DR. MACMASTER: Well, surely this contract

would be redesigned in a situation like that?

THE CHAIRMAN: You have a member of a

group, and he ceases to be a member of that group; has

he the absolute right to continue his membership, forever-

ting for the moment this 30-day business?

DR. MACMASTER: He has that right.

THE CHAIRMAN: I would like your explana-

tion on paragraph 14 in page 2: "Group coverage is

continued for retirees when requested by their group."

Now, is that a condition, that the group must request it,



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3 and it is not the option of the individual?

4 DR. MacMASTER: Well, the request is
5 conveyed to us by the agent of the group on behalf of
6 the retiree.

7 THE CHAIRMAN: So that is perhaps a little
8 awkwardly worded here?

9 DR. MacMASTER: It probably is, but the
10 intent is that we try to keep these retirees on the
11 group to which they belong, to get all the benefits of
12 that group rate, rather than the higher non-group rate.

13 THE CHAIRMAN: What would happen if the
14 groups said: "No, we don't want this chap carried", but
15 he wanted to be carried?

16 DR. MacMASTER: I think we have to take
17 notice of the wishes of the group. We are dealing with
18 the group, and we have some responsibility towards each
19 other. A situation like that, where there is any diffi-
20 culty, I suggest that the retiree should take a non-group
21 coverage and eliminate the problem. This is surely a
22 problem between the man and his group. Could Mr. Straight
23 speak to that Mr. Chairman?

24 THE CHAIRMAN: I think it is quite well
25 understood that anybody who wishes to explain or expand
26 the question is at perfect freedom to do so. What we are
27 looking for is information.

28 MR. STRAIGHT: The questions you are
29 asking are coming from an environment of competition
30 among voluntary organizations.

THE CHAIRMAN: You mean they are also
coming?

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MR. STRAIGHT: The questions you are

asking are coming from an environment of competition

among voluntary organizations.

THE CHAIRMAN: I'm sure they are also

coming?



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4 MR. STRAIGHT: Yes, that is correct. If
5 you transpose a set of circumstances that are new and
6 entirely different from what now obtains, then it is
7 only reasonable to expect M.M.S. to change its contracts,
8 and make adjustments accordingly. For example, the 30-
9 day cancellation clause might be changed to one which
10 says that the member may be a member of M.M.S. and a
11 subscriber for life, provided he meets the underwriting
12 requirements of the class to which he belongs and pays
13 the premium rate, but if you are talking of a comprehen-
14 sive scheme, covering almost the whole of the Province
15 under a voluntary scheme with little or no competition,
16 which is different than today, it would be a different
17 thing. If you impose new conditions, the method of opera-
18 ting would have to be adjusted, because right now M.M.S.
19 is in a competitive market.

20 THE CHAIRMAN: Thank you Mr. Straight.
21 Mr. Straight, if I may go back to another matter on which
22 I was seeking some information yesterday afternoon, and
23 that is the matter of drug costs. Are you in a position
24 to, from the experience you have had with M.M.S., to say
25 what the prescription drug costs is in Manitoba? I don't
26 mean to the dollar, but an approximate figure?

27 MR. STRAIGHT: I haven't any experience
28 with M.M.S. to give you that answer. I can borrow on
29 other places.

30 THE CHAIRMAN: Well, have you the knowledge?

MR. STRAIGHT: I believe I have enough
knowledge to give you an answer that is within your
working conditions. If you take \$9 per person per year,

you transpose a set of circumstances that are new and entirely different from what now obtains, then it is only reasonable to expect M.M.S. to change its contracts, and make adjustments accordingly. For example, the 30-day cancellation clause might be changed to one which says that the member may be a member of M.M.S. and a subscriber for life, provided he meets the underwriting requirements of the class to which he belongs and pays the premium rate, but if you are talking of a comprehensive scheme, covering almost the whole of the Province under a voluntary scheme with little or no competition, which is different than today, it would be a different thing. If you impose new conditions, the method of operating would have to be adjusted, because right now M.M.S. is in a competitive market.

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3 you will have a safe high figure for Manitoba for
4 prescribed drugs which are dispensed by a pharmacist on
5 the prescription of a physician.

6 THE CHAIRMAN: What do you mean by a safe
7 high figure?

8 MR. STRAIGHT: Well, it would be likely
9 to be less than that.

10 THE CHAIRMAN: What would be the range?

11 MR. STRAIGHT: Between eight and nine
dollars I believe.

12 THE CHAIRMAN: Are you in a position to
13 give any similar estimate on the cost of non-prescription
14 drugs to the people of Manitoba?

15 MR. STRAIGHT: You have to give me the
16 list of non-prescribed drugs. It is really an impossible
17 thing to estimate. If you include insulin, which is the
18 type of thing I think you have in mind, it does not need
19 a prescription. Some drugs for the treatment of glaucoma
20 are very expensive, and don't need a prescription, and
you think of the type of drug ---

21 THE CHAIRMAN: We are thinking of all the
22 advertised drugs: you take a pill and you are going to
23 be bouncing down the street.

24 MR. STRAIGHT: Bromo Seltzer, Seven-Up?
You produce a list and I will produce the estimate.

25 THE CHAIRMAN: I am not in the advertising
26 business. The answer is, I mean because of the wide
27 variety of commodities so sold it is impossible to ---

28 MR. STRAIGHT: I would suggest this:
29 another brief is in preparation for the Commission from
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3 the B.C. Pharmaceutical Association, where complete
4 samples are made of all prescribed drugs in 1960, and
5 I will ask them to give an estimate, store by store, of
6 the other drugs.

7 THE CHAIRMAN: I think it is information
8 which we are going to try to get, because we think it is
9 of some consequence. Thank you Mr. Straight.

10 COMMISSIONER STRACHAN: Paragraph 10 on
11 page 2 states: "M.M.S. offers a paid-in-full type program
12 for those with incomes under \$10,000 per year". Yet on
13 page 3, paragraph 20, in the middle of the paragraph you
14 state: "We have no data or basic statistics upon which
15 to judge income levels or ability to pay of present
16 subscribers and such information with respect to the
17 non-member public is not available to us in an adequate
18 form". And yet on page 16, paragraph 58, you state that:
19 "M.M.S. offers only a service-type program as distinct
20 from indemnity insurance. This provides for 'paid-in-
21 full' care by participating physicians for subscribers
22 and dependents whose combined annual income is not in
23 excess of \$10,000". It seems to me, Mr. Chairman, that
24 there are some inconsistencies in these statements.

25 THE CHAIRMAN: Do you wish somebody to
26 make an explanation in regard to them?

27 COMMISSIONER STRACHAN: How they arrived
28 at the \$10,000 income?

29 DR. McINTYRE: Mr. Chairman, this income
30 level is left to the patient's doctor. M.M.S. does not
attempt to establish the income level of the patient.

THE CHAIRMAN: How does the doctor



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THE CHAIRMAN: How does the doctor



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4 establish it? It is very easy for a judge, because he
5 is getting a statutory salary. Is there anybody else ---

6 DR. McINTYRE: That is left to the indivi-
7 dual doctor. Presumably he asks the patient, and
8 certainly if he extra-bills the patient and the patient
9 isn't over \$10,000, he soon hears about it.

10 COMMISSIONER McCUTCHEON: How many cases
11 have you had in the last year where there has been extra-
12 billing and complaints by your subscribers?

13 DR. McINTYRE: The complaints are usually
14 directed to that subscriber's doctor. They are not
15 directed to the M.M.S., as far as I know.

16 DR. MacMASTER: We have had no such
17 complaints.

18 COMMISSIONER STRACHAN: Are your subscri-
19 bers made aware of this \$10,000 figure?

20 DR. McINTYRE: Yes, they know about it.

21 MR. DEWAR: Mr. Chairman, it may not be a
22 matter of great difference, but that \$10,000 is family
23 income, not individually.

24 THE CHAIRMAN: Does that make it better,
25 or worse?

26 MR. DEWAR: No, it does not change the
27 figure, just the point of view of the way it is set out
28 in the agreement.

29 DR. ALLISON: Mr. Chairman, this clause
30 was introduced originally because many doctors found that
wealthy patients were a great deal more demanding and
troublesome than the average patient, and this was
simply put in as a protective clause, but it is very

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4 rarely used to my knowledge. For example, in my own
5 case I think I have only extra-billed on one occasion,
6 so that will give you some indication as to the impor-
7 tance of it.

8 THE CHAIRMAN: It is not a question of
9 \$10,000, or whatever it might be, but it is the idea of
10 a limitation which is concerning us at the moment. For
11 instance, in the Atlantic Provinces I think the figure
12 that appears in the contract there is \$5,000. Are you
13 aware, for instance, in perhaps the largest group of
14 prepaid medical coverage, the Hospital Insurance Plan in
15 New York, the H.I.P. has abandoned this term of its
16 contract of an income limitation completely. Dr. Mac-
17 Master, have you tried to follow through with other
18 plans?

19 DR. MacMASTER: Yes, I know well the
20 H.I.P. in New York is a little different, that is a
21 closed practice, is it not? I think that makes a
22 difference.

23 THE CHAIRMAN: So far as the subscriber
24 is concerned, he pays X dollars a year for medical
25 service?

26 DR. MacMASTER: Yes.
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4 THE CHAIRMAN: So, to that extent there
5 is no substantial difference. There is a difference in
6 the way the money is disbursed once it reaches the
7 carrier, H.I.P.?

8 DR. MacMASTER: Yes. Is there not another
9 reason here, that with the plan becoming larger in member-
10 ship that private practice becomes correspondingly
11 reduced?

12 THE CHAIRMAN: That is obvious.

13 DR. MacMASTER: Doesn't it then affect
14 the doctor's income that he would otherwise have from
15 private practice -- presumably higher income? I think
16 that may be a factor.

17 THE CHAIRMAN: In any event, for the
18 moment, the view of M.M.S. is that this type of thing,
19 of income limitation, should be maintained in your
20 contract?

21 DR. MacMASTER: I think in this connection
22 we have to take notice of the wishes of organized medi-
23 cine. We have contracts with each doctor, and I feel
24 that so long as the doctors wish a clause of this kind
25 that the M.M.S. corporation would be obliged to take heed
26 of it. However, probably organized medicine should
27 speak for this. The M.M.S. does have to take notice of
28 the wishes of the doctors.

29 THE CHAIRMAN: I see your position.

30 COMMISSIONER VAN WART: On page 3, Section
19, you make the statement, "Active care of the semi-
indigent group requires attention and a resulting subsidy
in a form which cannot properly be resolved by M.M.S."

THE CHAIRMAN: So, to that extent there is no substantial difference. There is a difference in the way the money is disbursed once it reaches the carrier, H.I.P.?

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THE CHAIRMAN: I see your position. COMMISSIONER VAN WART: On page 3, Section 19, you make the statement, "Active care of the semi-



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4 For the record, would someone define for me what you
mean by "semi-indigent"?

5 DR. ALLISON: As you are well aware, Mr.
6 Chairman, this is a difficult matter to define entirely.
7 Indigents are defined as recipients of social allowances.
8 We might say roughly that semi-indigents would be the
9 group above this, and yet include those who would find
10 it difficult to pay M.M.S. subscriptions. This matter
11 has been studied by Dr. Clarence Barber, an economist
12 at the University of Manitoba, engaged by the Manitoba
13 Medical Association, and you will receive in the Manitoba
14 Medical Association brief the full details of studies
15 of income levels at which it is thought subsidy is
16 desirable. There is also another method of defining a
17 semi-indigent, and that is someone below the level of
18 paying income tax to the Dominion Government. Presumably
19 the Government considers that people below this level
20 are not in a position to support the tax structure.

21 COMMISSIONER VAN WART: Have you any
22 estimate of the percentage of the population who would
23 fall into this class?

24 DR. ALLISON: Yes, we have, and these
25 figures are given in Dr. Barber's report. While we are
26 on this subject, perhaps I might say a word with respect
27 to the figure of 350,000 people which was used yesterday
28 on a number of occasions as being the number of people
29 in this province who do not belong to prepaid plans of
30 any sort. I would like to point out that this number
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5 contracts is better known. Incidentally, the premium
6 set by M.M.S. for complete coverage of single individuals
7 in rural areas is \$1.93 per person per month, which is
8 less than the figure mentioned by Mr. Roblin yesterday
9 in the matter of the \$24 a year low fixed premium. This
10 gives you an indication of the smaller amount of premium
11 necessary in rural areas compared to the city areas.

12 COMMISSIONER VAN WART: To your knowledge,
13 has any other group made a study of the semi-indigent
14 group outside of the Manitoba Medical Association and
15 yourself?

16 DR. ALLISON: Dr. Barber's figures are
17 based on many different studies; social welfare allowances
18 -- you will find the sources of his information, I think,
19 in the submission.

20 COMMISSIONER VAN WART: If your group were
21 making a subsequent submission to the Commission would
22 you be able to include your data and your conclusions
23 regarding this group of semi-indigents in that submission?

24 DR. ALLISON: Mr. Chairman, I trust that
25 you will find enough information in Professor Barber's
26 report to cover this whole matter.

27 COMMISSIONER VAN WART: Well, we are
28 looking for further information.

29 DR. ALLISON: You mean after studying his
30 report?

31 COMMISSIONER VAN WART: If you acquire
32 further information, would you submit it to us in a

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3 subsequent submission?

4 DR. ALLISON: If M.M.S. acquires further
5 information, certainly we will, sir.

6 COMMISSIONER FIRESTONE: Dr. McIntyre,
7 if I may crave your indulgence, may we perhaps turn
8 first to paragraph 6 of your submission on page 1. You
9 say that as of September 30th 1961 there were 729 medical
10 members servicing Greater Winnipeg, and 245 beyond the
11 Greater Winnipeg area. The 729 medical members serving
12 Greater Winnipeg -- what proportion is this of the total
number of physicians in Greater Winnipeg?

13 DR. MCINTYRE: I would think 100%, sir.

14 COMMISSIONER FIRESTONE: Well, I looked
15 at the statistics presented to us by the Government of
16 Manitoba, and they advised us there was a total of 807
17 doctors in 1959 in Greater Winnipeg. The figures are not
18 quite comparable because the only published figure
19 available to us was the 1959 figure, and we are not quite
20 sure whether the definition is the same, but it does
21 suggest there are some physicians who are not participa-
ting members; would that conclusion be correct?

22 DR. MCINTYRE: Yes, that is right. They
23 are not practising physicians; they are company doctors
24 and those holding university appointments.

25 COMMISSIONER FIRESTONE: The point you are
26 making is that all physicians in the Greater Winnipeg
area -- all practising physicians are participating?

27 DR. MCINTYRE: Yes, with the exception of
28 possibly one or two.

29 COMMISSIONER FIRESTONE: In other words,
30

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5 sion in administering such a scheme in Greater Winnipeg?

6 DR. McINTYRE: That is correct.

7 COMMISSIONER FIRESTONE: That is a most
8 encouraging feature. In paragraph 8 on the same page
9 you say that your operating expenses amounted to 6.5% of
10 earned subscriptions in 1960: were there any funds put
11 into reserves that year?

12 MR. MacDONELL: In statement No. E5, Mr.
13 Chairman, you will see that the medical doctors who were
14 actually on our prorating payment were actually overpaid
15 by an amount of \$25,569. So, it can be said in the year
16 1960 there was actually a reduction of reserves by that
17 amount, but reserves that had been set up for previous
18 years. At the year end there was naturally an estimate
19 made of clean-up necessary for year end. The doctors'
20 prorating for the year is set, and then there is a small
21 adjustment figure one way or another. In this particular case
22 the reserves were reduced by \$25,000.

23 COMMISSIONER FIRESTONE: Just to give the
24 Commission an approximate understanding of how you
25 operate, would it be fair to say you are paying out
26 something like 90 to 93¢ of the dollar that you are
27 receiving? If you had no reserves you would have paid
28 out about 93¢ out of a dollar?

29 MR. MacDONELL: Between operating expenses
30 and doctors' prorating we were paying 100% in 1960 --
slightly over 100%.

31 COMMISSIONER FIRESTONE: Yes, but you were
32 saying the experience of 1960 was somewhat different from

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COMMISSIONER FIRSTONE: That is a most

encouraging feature. In paragraph 8 on the same page you say that your operating expenses amounted to 6.23 of earned subscriptions in 1960; were there any funds put

Chairman, you will see that the medical doctors who were actually on our operating payment were actually overpaid by an amount of \$25,582. So, it can be said in the year 1960 there was actually a reduction of reserves by that amount, but reserves that had been set up for previous years. At the year end there was naturally an estimate made of clean-up necessary for year end. The doctors' proportion for the year is set, and then there is a small adjustment figure one way or another. In this particular the reserves were reduced by \$25,582.

COMMISSIONER FIRSTONE: Just to give the

Commission an approximate understanding of how you operate, would it be fair to say you are paying out something like 90 to 95 of the dollar that you are receiving? If you had no reserves you would have paid out about 85 out of a dollar?

and doctors' operating we were paying 100% in 1960 --

slightly over 100%.

COMMISSIONER FIRSTONE: Yes, but you were

saying the experience of 1960 was somewhat different from



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3 the earlier years where you had been able to put some
4 money away into reserves. So, would you say over the
5 years you are paying out something like 90 to 93¢ or 90
6 to 95¢ out of the dollar? We are not looking for an
7 exact figure.

8 MR. MacDONELL: There is an exact figure
9 available on statement E1 which shows that we paid out
10 to doctors over the period 62,800,000 on medical claims
11 of 77,315 with the reduction of 14.5 million. Our
12 reserves in the meantime have accumulated roughly to the
13 amount of 1.1 million. So 1.1 million of the reduction
14 of 14.5 million went into reserves over a period since
15 1944.

16 COMMISSIONER FIRESTONE: That works out
17 roughly to about 7%; is that correct? In other words,
18 you are confirming that you have been paying out about
19 93¢ out of the dollar?

20 MR. MacDONELL: That is about right, yes.

21 COMMISSIONER FIRESTONE: Is that right,
22 sir?

23 MR. MacDONELL: That is about right.

24 COMMISSIONER FIRESTONE: In other words,
25 we have here a scheme where you approximately -- and I
26 am not pinning you down to the last cent -- where you
27 are approximately paying out about 93¢ out of the dollar
28 to cover medical services which your subscribers receive?

29 MR. MacDONELL: You realize, of course,
30 that over the earlier periods of the plan it was necessary
to build up reserves to a greater extent than it is neces-
sary as the plan matures, and that the doctors are getting



the earlier years where you had been able to put some money away into reserves. So, would you say over the years you are paying out something like 50 to 83¢ or 80 to 95¢ out of the dollar? We are not looking for an exact figure.

available on statement B1 which shows that we paid out to doctors over the period of \$2,500,000 on medical claims of 77,315 with the reduction of 14.5 million. Our reserves in the meantime have accumulated roughly to the amount of 1.1 million. So 1.1 million of the reduction of 14.5 million went into reserves over a period since

COMMISSIONER FERGUSON: That works out roughly to about 75¢; is that correct? In other words, you are confirming that you have been paying out about 93¢ out of the dollar?

MR. MACDONALD: That is about right, yes.
COMMISSIONER FERGUSON: Is that right?

MR. MACDONALD: That is about right.

COMMISSIONER FERGUSON: In other words,

we have here a scheme where you approximately -- and I am not pinning you down to the last cent -- where you are approximately paying out about 93¢ out of the dollar to cover medical services which your subscribers receive; MR. MACDONALD: Yes realize, of course,

that over the earlier periods of the plan it was necessary



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3 a higher prorating for that reason as well as other
4 reasons at the present time than they were in the
5 earlier years.

6 COMMISSIONER FIRESTONE: The implication
7 of what you are saying, if I understand you correctly,
8 is that this 93¢ experience over the past may even be
9 improved to 95¢ in the future because of less reserve
10 requirements?

11 MR. MacDONELL: It very well could be.

12 COMMISSIONER FIRESTONE: In other words,
13 it is somewhere between 93 to 95¢ that you have been
14 paying out, or may be paying out in the future? This is
15 a very good record, sir. Are you familiar with the fact
16 that some commercial carriers pay out between 40 and 50¢
of the dollar received?

17 MR. MacDONELL: I am not familiar with it,
18 but I know in connection with other types of insurance
19 it is so.

20 COMMISSIONER FIRESTONE: In other words,
21 the people of Manitoba are getting a very good deal by
22 becoming subscribers to your plan: do you agree with that?

23 MR. MacDONELL: Yes. Of course, you have
24 to take into account in fairness to the private insurance
25 company that there is very close to universal coverage,
26 particularly in the City of Winnipeg, and naturally the
operating costs are higher on a regulating basis and
there is a lower element of profit involved.

27 COMMISSIONER FIRESTONE: But the fact
28 remains subscribers to your plan are getting a very good
29 return for the amount of money they invest in the scheme.
30



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4 MR. MacDONELL: Either that or the doctors
5 are getting more -- the doctors are getting more and the
6 subscribers are paying less.

7 COMMISSIONER FIRESTONE: Let us turn to
8 the doctors in the same paragraph 8 where you say that
9 in 1960 under your prorating plan payments to medical
10 members were 88.7% of assessed claims; does this mean --
11 and perhaps I should address the question to Dr. McIntyre
12 -- that doctors do subsidize the plan to the extent of
13 11.3¢ out of every dollar?

14 THE CHAIRMAN: Of the assessed claim.

15 COMMISSIONER FIRESTONE: Of the assessed
16 dollar.

17 DR. McINTYRE: No, I don't think so. I
18 think the difference would be between the 88.7¢ minus
19 the administrative expense.

20 COMMISSIONER FIRESTONE: Pardon?

21 DR. McINTYRE: It would be minus the
22 administrative expense.

23 COMMISSIONER FIRESTONE: In other words,
24 you are saying the doctors have been subsidizing between
25 88.7 and 93.5; is that what you are saying?

26 DR. McINTYRE: Yes.

27 COMMISSIONER FIRESTONE: In other words,
28 you are suggesting that the doctors are subsidizing the
29 scheme to a certain extent by taking less in fees?

30 DR. McINTYRE: Yes, sir; they always have
and still are.

COMMISSIONER FIRESTONE: If there were a
scheme devised whereby either through premiums or



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4 Government contributions the total cost incurred or the
5 total fees charged by the doctors were covered, would
6 such a scheme not be in the interests of physicians
7 because they would then not have to subsidize a scheme?

8 DR. McINTYRE: Mr. Chairman, the medical
9 profession have always subsidized segments of the society,
10 and I think they are prepared to continue to do that.
11 The Manitoba medical scheme is gradually becoming more
12 and more sound financially, and I would hate to think
13 that for the sake of a few dollars that we would jeopardize
14 our freedom, because this might conceivably happen
15 if we were subsidized to any great extent by any one
16 government.

17 COMMISSIONER FIRESTONE: In other words,
18 you are saying that you prefer the doctors to subsidize
19 a scheme to the community as a whole; is that what you
20 are saying?

21 DR. McINTYRE: What I am saying is we
22 prefer to maintain freedom of practice, and if this
23 involves a certain area of subsidization -- I am not
24 speaking officially now; this is a personal opinion --
25 if this involves an area of subsidization, the medical
26 profession has always done this, and I think they are
27 prepared to continue to do it to a certain extent.

28 COMMISSIONER FIRESTONE: I am glad, Dr.
29 McIntyre, you add the phrase "to a certain extent",
30 because you are quite right: even physicians can only
carry a subsidy so far. If the scheme were to be extended
to cover everybody, or almost everybody in the province,
you could not expect the physicians to carry on the



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4 subsidy that would be required to make the scheme pay,
5 and therefore presumably a community responsibility would
6 be involved. Would you agree with that?

7 DR. McINTYRE: Yes, sir.

8 COMMISSIONER FIRESTONE: May I now turn
9 to paragraph 11 on page 2. You say that comprehensive
10 medical care plans are preferred by most people covered,
11 and you mention 82%. I take it this is in line with the
12 principle expressed in paragraph 2 of the supplementary
13 brief of the Manitoba Medical Association in which the
14 Association says that it advocates a universally
15 available medical service on a comprehensive basis, and
16 then this paragraph proceeds to define what you mean by
17 "comprehensive". I take it this plan that you have
18 developed is in line with this principle that the Manitoba
19 Medical Association submitted to us?

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COMMUNITY RESPONSIBILITY

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brief of the Manitoba Medical Association in which the
Association says that it advocates a "comprehensive
available medical service in a comprehensive sense, and
then this paragraph proceeds to define what you mean by
"comprehensive". I take it that you mean that you
covered is in line with that which is that the
Medical Association continues to say



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4 DR. McINTYRE: Yes sir, it has been
5 developed in conjunction with the Manitoba Medical
6 Association.

7 COMMISSIONER FIRESTONE: If I understood
8 your counsel correctly he suggested that the Association
9 is somewhat apprehensive to sell such a comprehensive
10 medical care plan. Would you elaborate and give us the
11 reason for that?

12 DR. MacMASTER: I did not quite get that,
13 you speak of a comprehensive plan.

14 COMMISSIONER FIRESTONE: Paragraph 11,
15 comprehensive medical care plan.

16 DR. MacMASTER: It is a question of a
17 desire to continue to sell this plan.

18 COMMISSIONER FIRESTONE: I am referring to
19 a statement that your counsel made and I took it down
20 when he made it. He said that your group is apprehensive
21 to sell this plan and if he did not say that would you
22 please advise?

23 THE CHAIRMAN: Which plan?

24 MR. DEWAR: It is on page 18.

25 THE CHAIRMAN: I know where it is, it was
26 the contract, the first one.

27 DR. MacMASTER: I see it is at page 18:
28 "While we have mental reservations about selling this
29 wide benefit program indiscriminately ---". There are
30 places in Manitoba where facilities are inadequate, very
few doctors and those who are selling this program have
to take that into account in selling. All we do is pay
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4 with the doctor providing the service. It is assumed
5 that we have responsibility for providing his service
6 which is quite inaccurate. Our field men feel very keenly
7 that they have to taper down the demand sometimes. Many
8 people want the best and are willing to pay for the best
9 but our field people have to meet these people again.
10 With a comprehensive program they cannot get the service
11 and it is a little difficult for us to explain why they
12 could not get the service. We say that all we are doing
13 is paying the bills for service, we cannot see that the
14 service is rendered. I think that is probably what we
15 had in mind when we said we had mental reservations
16 about selling it indiscriminately. It is sort of a moral
17 obligation in the field of selling, we must not oversell.

18 COMMISSIONER McCUTCHEON: You are trying
19 to sell honestly?

20 DR. MacMASTER: That is the way we feel
21 about it.

22 MR. GREENE: On behalf of the subscribers
23 I think it should be understood there is a different
24 opinion among subscribers in that some of them want comprehen-
25 sive care and I am inclined to think most of them do.
26 However, there are many who will insist only on covering
27 catastrophic costs and there should be a freedom of
28 choice.

29 THE CHAIRMAN: That statement is in
30 reference to the comprehensive care, HCX?

MR. GREENE: The statement suggests that
HCX should not be compulsory, that there should be some-
thing else.



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4 THE CHAIRMAN: The statement is the
5 comprehensive plan HCX is the plan most preferred. In
6 view of that statement I feel we are talking about the
7 HCX in this context, in the context of the question.

8 MR. GREENE: I am suggesting that HCX
9 should not be sold indiscriminately, there should be
10 another choice if at all possible. I also suggest that
11 Plan HCX should not be developed to the point where it
12 covers all health costs indiscriminately in the
13 interests of the subscriber; there are subscribers who
14 do not want it.

15 THE CHAIRMAN: You had better re-word
16 your statement if that is what you want to say. I would
17 prefer to accept Dr. MacMaster's explanation that you
18 cannot sell it indiscriminately unless you can provide
19 the service.

20 MR. GREENE: He is talking in terms of
21 ability to sell the plan, I am talking in terms of the
22 wishes of the subscribers that want an alternative.

23 COMMISSIONER FIRESTONE: Is it a fact that
24 the majority of your subscribers wish to have a comprehen-
25 sive plan?

26 MR. GREENE: I would say the majority, yes.
27 It becomes a problem when you are dealing with groups,
28 you have many within a group who prefer to pay a lower
29 premium for a less comprehensive plan but the group major-
30 ity in that particular group wins the day.

31 COMMISSIONER FIRESTONE: Then if we can
32 proceed in terms of what the majority wants and you have
33 told us that the majority wants a comprehensive plan.



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4 Now, there is some hesitation or mental reservation about
5 selling the plan because in some areas or some instances
6 there may not be the services available for which this
7 comprehensive plan provides coverage. What are such
8 instances?

9 DR. MacMASTER: Some of the rural areas
10 are quite a distance from a hospital with perhaps one
11 elderly doctor with a wide territory. Our people feel
12 sometimes while there is demand for a comprehensive
13 program the service will not be delivered unless they go
14 quite a distance, probably come right into Winnipeg.

15 COMMISSIONER FIRESTONE: In other words,
16 let us say you have sold a farmer living in a rural area
17 a comprehensive plan and a physician feels that he should
18 have an x-ray and there is no x-ray facility nearby.
19 In that case the farmer has to travel to the nearest
20 hospital for an x-ray but he would still be covered?

21 DR. MacMASTER: Oh, yes.

22 COMMISSIONER FIRESTONE: Why are you
23 reluctant to sell him that coverage if he is willing to
24 travel that 100 miles? He still wants to be covered.

25 DR. MacMASTER: I think if you take a look
26 at the whole situation and not apply it to one farmer -
27 I think the whole picture has to be taken into account
28 by our salesmen. Please do not misunderstand us, we are
29 selling Plan HCX but our people feel there are situations
30 when a little common sense has to be exercised. This is
much like selling people a Cadillac when a Chevrolet is
probably all they need. It is just a matter of selling.

COMMISSIONER FIRESTONE: I was under the

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3 understanding you supported the free enterprise system.
4 If people want to buy a Cadillac why do you want to
5 persuade them to buy a Chevrolet?

6 DR. MacMASTER: It is a matter of going
7 out and just - well, I would still feel a certain sense
8 of conscience.

9 COMMISSIONER FIRESTONE: You would not
10 like to go back the next year?

11 DR. MacMASTER: I would think I would ask
12 someone else the next time.

13 THE CHAIRMAN: If you oversold you would
14 stay away the next time?

15 DR. MacMASTER: I think so and with good
16 reason.

17 COMMISSIONER FIRESTONE: But the fact is
18 you are in agreement with the basic principle that the
19 Medical Association has submitted to us - they will be
20 submitting to us that you are in favour of that principle
21 and in effect you are trying to implement a principle
22 which the Manitoba Medical Association has explained to
23 us in their supplementary submission and that is to make
24 available and universally available a service plan on a
25 comprehensive basis. That is in paragraph 2 of their
26 supplementary submission.

27 Now, may I turn to another question,
28 paragraph 17 on page 3. Dr. McIntyre, may I direct the
29 question to you? In this paragraph you say that you have
30 the administrative organization necessary to expand the
operations to a more universal coverage to Manitoba citi-
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zens. Could you please explain to us what you mean by



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3 "more universal"?

4 DR. McINTYRE: That is geographic.

5 COMMISSIONER FIRESTONE: You have at the
6 moment about 400,000, close to 400,000 people covered
7 out of 900,000; what does "more universal" mean?

8 DR. McINTYRE: It means geographical and
9 numerical.

10 COMMISSIONER FIRESTONE: Does it mean
11 500,000 or 600,000 or does it mean everybody?

12 DR. McINTYRE: As many as want to volunteer
13 to buy it.

14 COMMISSIONER FIRESTONE: I take it "univer-
15 sal" means everybody; how can you have "more universal"?

16 THE CHAIRMAN: We will let the grammarians
17 discuss that.

18 COMMISSIONER FIRESTONE: Your objective is
19 to cover as many people as you can possibly cover under
20 the fee schedule, the premium schedule which you have?

21 DR. McINTYRE: On a voluntary basis.

22 MR. GREENE: May I suggest that the objec-
23 tive is to make it available particularly throughout
24 rural Manitoba to a greater extent than it is now
25 available.

26 COMMISSIONER FIRESTONE: Well, on page 5,
27 paragraph 27 you outline to us how you - how the Manitoba
28 Medical Service is administered and you refer to a 24-
29 member Board. Now, we were talking a little earlier of
30 the medically indigent and presumably if you were to
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3 in that?

4 DR. McINTYRE: Some sort of subsidy from
5 someone.

6 COMMISSIONER FIRESTONE: From some govern-
7 ment?

8 DR. McINTYRE: From some source.

9 COMMISSIONER FIRESTONE: Presumably the
10 source would include a government?

11 DR. McINTYRE: That is your assumption,
12 is it not?

13 COMMISSIONER FIRESTONE: What would be
14 your assumption of what the source would be?

15 DR. McINTYRE: I would sooner leave it
16 just as some source.

2 17 COMMISSIONER FIRESTONE: Would you have
18 no views as to what the source might be?

19 DR. McINTYRE: Yes, I have views. I
20 think the Medical Association will explain what sources
21 they think.

22 COMMISSIONER FIRESTONE: In other words,
23 you would prefer the Manitoba Medical Association to
24 deal with this question rather than your own organization,
25 is that it?

26 DR. McINTYRE: Yes.

27 COMMISSIONER FIRESTONE: This raised a
28 bit of difficulty because the next question I was going
29 to ask you was how would you feel to have on your Board
30 representatives of the Government. By saying "a govern-
ment" we cannot identify which government but a government,
assuming that your society would be in receipt of subsidies



DR. McINTYRE: Some sort of subsidy from

ment?

DR. McINTYRE: From some source.

COMMISSIONER FIRESTONE: Presumably the

source would include a government?

DR. McINTYRE: That is your assumption.

is it not?

COMMISSIONER FIRESTONE: What would be

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4 from a government. Presumably when a government contri-
5 butes to a scheme they will want to have a say in the
6 matter. How would your Association feel having among
7 the members of your Board representatives from the Govern-
8 ment?

9 DR. McINTYRE: Indeed, now we are receiving
10 subsidy from the Provincial Government for the Medicare
11 people and it has been discussed that government might
12 have representation on the Board. This was just an infor-
13 mal discussion, it had not been discussed formally at a
14 Board meeting but there seems to be no great concern
15 about having representatives of government on the Board.

16 COMMISSIONER FIRESTONE: In other words,
17 you would be agreeable to having members of government
18 on the Board as and when the government makes a larger
19 contribution than it is making now, in the case of an
20 expansion of the program?

21 DR. McINTYRE: I am not saying that because
22 it has not been discussed formally by the Board.

23 COMMISSIONER FIRESTONE: Could you give us
24 your own views as the head of this organization, what
25 would be your views on the subject?

26 DR. McINTYRE: As I stated, this has been
27 discussed informally and there is no great concern
28 expressed by the representation of government on the
29 Board so I would not anticipate any difficulty.

30 COMMISSIONER FIRESTONE: Fine, I accept
that as an explanation. May I now turn to paragraph 41
on page 10 and you mention there that you have a total
coverage of about 395,000 people; group coverage 337,000

from a government. Presumably when a government contributes to a scheme they will want to have a say in the

DR. McINTYRE: Indeed, now we are receiving

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that as an explanation. May I now turn to paragraph 11 on page 10 and you mention there that you have a total



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3 and non-group about 58,000. In determining the rate for
4 these various groups what methods do you follow?

5 MR. STRAIGHT: The principles are quite
6 simple. Once the organization is under way the initial
7 rates were guesses. The rates for a pool of groups or
8 a single group are calculated by referring to the actual
9 cost of medical services for the group for a period of
10 time, usually a year. Those costs then are adjusted for
11 any increase or decrease in the benefits such as a minor
12 change in the fee schedule, an indicated possible change
13 in the proration figure if that is desired and some
14 allowance for increases in utilization. Then an allowance
15 is made for administration expenses and if reserves are
16 being accumulated or a safety margin is being put in the
17 rate because it may be an experimental rate, another
18 allowance is put in. Most of the rate is coming up on
19 actual administrative expenses and actual claims with
20 minor adjustments for those factors. For instance, in
21 the most recent major modification of rates in 1961 the
22 actual claims experience was used; an estimate of admini-
23 stration expenses plus a 10% allowance for an increase in
24 claims cost on the groups by reason of adding benefits,
25 the main one being only mildly limited complete physical
26 examinations. That is an experimental rate but if there
27 were not such a benefit the allowance might be 2% or 3%.
28 In some years there has been no allowance.

29 COMMISSIONER FIRESTONE: How does a non-
30 group rate compare with a group rate?

MR. STRAIGHT: It is higher for several
reasons. First of all, an actual experience of the



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COMMENT: SLOWLY INCREASED. How does a non-

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4 non-group rate claims cost, let us say it increased in
5 person as distinguished from a family, the actual costs
6 are higher than the cost of individual contract holders
7 in all groups combined.

8 There are many reasons for this, the
9 principal one being that they are older. There is a
10 heavier administration expense but the same administration
11 factor was used in both the group and non-group calculations.
12 In other words, the groups subsidize the non-
13 groups through the administration. It is more expensive
14 to collect the premiums on the non-groups, but there is
15 no extra charge for that. The non-group premium is
16 higher, mainly because of the age.

17 One feature of Manitoba Medical's rates,
18 which I think may be of interest to the Commission, is
19 you have a rate structure that is based on three rates,
20 say, \$3 for a person by himself, \$6 for a couple, and
21 \$9 for three or more. That is commonly called a three-
22 rate structure. You get into trouble when you try to
23 cover the aged. If you have only a two-rate structure,
24 which is, say, \$4 for one person and \$8 for two or more,
25 then you get this curious effect when you attempt to
26 cover the aged. The person who is in a couple is required
27 to pay \$8. If you had a three-rate structure you would
28 only be paying \$6. Older couples are more expensive
29 than younger couples. They have more hospital service
30 and surgery. If you put them on the rate structure, this
four and eight dollars, you collect more from them. If
you put them on the three, six and nine, you put them on
the \$6 rate. This means if you have only a two-rate

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4 structure, as Manitoba Medical has, these older couples
5 who have no children and no maternity costs, and who pay
6 for that, are paying the same rate as everybody else,
7 but they have the additional benefits of more hospital
8 service and more surgery, so that by luck this rate
9 structure works out so that you don't have to load the
aged people.

10 COMMISSIONER FIRESTONE: If I understand
11 you correctly, sir, you have averaged the rate payable
12 by the non-group subscribers?

13 MR. STRAIGHT: That is correct.

14 COMMISSIONER FIRESTONE: Irrespective of
age?

15 MR. STRAIGHT: Yes.

16 COMMISSIONER FIRESTONE: Thank you very
17 much. May I now turn to page 11, paragraph 46, sub-
18 paragraph 4, Unemployed: You say in this paragraph that
19 membership continues if the subscription rate is paid.
20 Sometimes the subscriber reduces his coverage to Plan
21 H with its comparatively lower rate. He is reinstated
22 to the higher level on his return to work. What happens
23 in the interim if he cannot pay the premium, not even
the premium to the reduced coverage?

24 DR. MacMASTER: The contract terminates
25 sir.

26 COMMISSIONER FIRESTONE: How does the
27 unemployed then receive or pay for his medical care
services?

28 DR. MacMASTER: I do not know.

29 DR. ALLISON: Such a person has two
30



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COMMISSIONER FIRESTONE: Thank you very much. May I now turn to page 11, paragraph 16, sub-paragraph 4, Unemployed. You say in this paragraph that membership continues if the subscription rate is paid. Sometimes the subscriber reduces his coverage to Plan B with its comparatively lower rate. He is reinstated to the higher level on his return to work. What happens in the interim if he cannot pay the premium, not even the premium to the reduced coverage?

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DR. HARRIS: I do not know.
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4 alternatives. He can either receive free service from
5 his own doctor, the doctor knowing the circumstances,
6 or he can attend the out-patient department of any of the
7 teaching hospitals, or be admitted to the in-patient of
such hospitals, at no charge.

8 COMMISSIONER FIRESTONE: In other words,
9 he would depend on charity?

10 DR. ALLISON: Yes.

11 COMMISSIONER FIRESTONE: Thank you.

12 THE CHAIRMAN: Dr. McIntyre, anticipate
13 that there may be a change in program, and perhaps even
14 without that, has M.M.S. given consideration to trying to
15 work out some formula by which coverage would be main-
16 tained over a period of unemployment, or something of
that kind, so as to bridge this gap in coverage?

17 DR. McINTYRE: Yes sir, I think the Mani-
18 toba Medical Association will be answering this question
19 in their brief. However, it has been discussed with them,
20 and there are various solutions, and suggested solutions
which I am sure they will elaborate on.

21 THE CHAIRMAN: You will appreciate that
22 this is a practical problem that somebody has to face?

23 DR. McINTYRE: Yes sir, and we have
24 discussed it.

25 COMMISSIONER FIRESTONE: Dr. McIntyre, do
26 your contracts provide for your Association the right to
cancel a policy?

27 DR. McINTYRE: This was discussed earlier,
28 Mr. Commissioner, on 30 days notice it says in the
29 contract.
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4 COMMISSIONER FIRESTONE: What was the last
half of your sentence?

5 DR. McINTYRE: It is in the contract that
6 it can be cancelled on 30 days notice.

7 COMMISSIONER FIRESTONE: Have you made use
8 of that right of cancellation?

9 DR. McINTYRE: No sir.

10 COMMISSIONER FIRESTONE: Under what cir-
cumstances would you cancel a policy?

11 DR. McINTYRE: Only if the premiums were
12 not paid, or the underwriting requirements were not met,
13 or misrepresentation was made concerning certain members
14 in a group.

15 COMMISSIONER FIRESTONE: But you would not
16 cancel because of the fellow having been sick a lot, and
17 you have paid a good deal more than he has paid in
premiums?

18 DR. McINTYRE: Certainly not.

19 COMMISSIONER FIRESTONE: You are familiar
20 with the fact that some commercial carriers do so?

21 DR. McINTYRE: Yes sir.

22 COMMISSIONER FIRESTONE: You are?

23 DR. McINTYRE: Yes sir.

24 COMMISSIONER FIRESTONE: And therefore
25 again somebody having coverage with your Association gets
26 a much better deal, as far as cancellation arrangements
27 are concerned, than he would get under certain commercial
28 coverage plans? I say certain, because there are diffe-
rences among the commercial carriers as well.

29 DR. McINTYRE: That is what we do sir.
30



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4 THE CHAIRMAN: On this subject, have you
5 made a practice at all of adding a rider to the contract
6 after a specific illness, or series of illnesses?

7 DR. McINTYRE: No sir.

8 COMMISSIONER FIRESTONE: You provide
9 comprehensive coverage to a large number of your subscri-
10 bers. Have you had any experience with misuse of the
11 plan through over-utilization, with patients coming to
12 see a doctor too many times, and physicians misusing, or
13 the patients trying to misuse the scheme? Have you had
14 much experience with what is called generally over-utiliza-
15 tion?

16 DR. McINTYRE: This is a question that is
17 difficult to assess. However, we feel that we have a
18 safety mechanism in our methods of rating. If one group
19 is over-utilizing the service, it is reflected in their
20 premium rates.

21 COMMISSIONER FIRESTONE: Have you had any
22 concrete experiences or complaints leading to investiga-
23 tions because of over-utilization?

24 DR. MacMASTER: Mr. Chairman, you say
25 because of over-utilization. The difficulty I have is
26 in knowing just what is meant by over-utilization. You
27 are getting into a very subjective area here, and
28 certainly from our experience in assessing claims we
29 find extreme difficulty in saying this was or was not
30 over-utilization in a particular case. I think the
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5 Dr. McIntyre says, we are prepared to let the people
6 have their care, knowing full well that eventually it
7 has to be paid for.

8 COMMISSIONER FIRESTONE: In other words,
9 if I understand you correctly, you have relied on the
10 good judgment of the physicians of Manitoba, and based
11 on that experience you have no knowledge of over-utiliza-
12 tion?

13 DR. MacMASTER: That would be my point of
14 view sir.

15 COMMISSIONER FIRESTONE: Based on that
16 experience you have therefore not found it necessary to
17 provide for deterrents, is that correct?

18 DR. MacMASTER: Well, not for that reason.
19 A deterrent I think to be effective must be substantial,
20 and I feel it will negate all the preventive care that we
21 set out to provide, the well baby care and so forth, and
22 immunization. I think the problem is where to put this
23 charge, to prevent them getting service, or let them have
24 the service and then pay for it.

25 THE CHAIRMAN: If you ever went to a uni-
26 form premium you would not have that device available to
27 you. How would you contemplate dealing with it in that
28 case, of a uniform premium?

29 DR. MacMASTER: Well, I wouldn't want to
30 take that responsibility, Mr. Chairman, to put a deterrent
31 in. I feel if a deterrent goes in it has to be very
32 substantial, otherwise it is a farce. If that is going
33 to be effective there are going to be very many disillusioned



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4 patients. It may be all right starting a program with
5 deterrents, but when you have had 16 years experience
6 and then ask 400,000 people to change their philosophies,
7 and ask the medical profession too, I think there is a
8 problem, probably a political problem there. So far as I
9 know, the M.M.S. is opposed to deterrents for the personal
10 service of a physician. In the City Corporation we have
11 had deterrents on account of the para-medical services,
12 drugs and other things, but not for the personal services
13 of physicians.

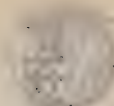
14 COMMISSIONER FIRESTONE: Dr. McIntyre, I
15 recall the Chairman asked a little earlier whether your
16 Association would be in a position to administer a prepaid
17 drug plan and I believe the answer we received was yes.
18 Would you say that your group would consider a prepaid
19 drug plan a useful supplement to the medical insurance
20 scheme which you now provide?

21 DR. MCINTYRE: What do you mean by useful,
22 Mr. Commissioner?

23 COMMISSIONER FIRESTONE: By a useful scheme
24 I mean a scheme that would supplement the service which
25 you now provide, and would be helpful to your subscribers.

26 DR. MCINTYRE: Well, any added benefit
27 would certainly supplement the coverage that we now provide,
28 and I am sure that people find it useful to have any of
29 their bills paid. We know of no great demand on the part
30 of our subscribers for the institution of such an addi-
tional benefit.

31 COMMISSIONER FIRESTONE: In other words,
32 you have no views at this point whether it would be a



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4 useful supplement or not? Am I right in that understand-
5 ding?

6 DR. McINTYRE: Well, we have no indication
7 from the subscribers that they think it would be a useful
8 supplement.

9 COMMISSIONER FIRESTONE: Have you made a
10 survey to find out how your subscribers would feel about
11 it?

12 DR. McINTYRE: Yes we have sir. This was
13 a Market Opinion Research Survey that the Manitoba Medical
14 Service conducted in the summer of 1959, and the benefits
15 named were dental care, prescribed drugs out of hospitals.
16 The total who wanted additional benefit was 71.3%, and
17 of the benefits named, dental care 56.2% wanted the
18 dental care. Prescribed drugs out of hospital 32.8%.
19 Optometry service 18.8%. Ambulance service 13.1%.
20 Special nurses in hospitals 7.1%. Blood plasma and intra-
21 venous feeding 6.0%.

22 COMMISSIONER FIRESTONE: Dr. McIntyre, I
23 believe you were present yesterday when we listened to
24 the submission of the Minister of Health, the Honourable
25 Dr. Johnson. In his submission, on page 48, he explained
26 to us that the Province of Manitoba discovered when they
27 called for tenders for drugs that there were differences
28 between the highest and lowest prices quoted of one parti-
29 cular drug of 491%. Would you feel that if this informa-
30 tion and similar information were to be made available
to your subscribers that they would realize that substan-
tial savings could be achieved through a prepaid drug
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COMMISSIONER FIRESTONE: Dr. McIntyre, I

believe you were present yesterday when we listened to the submission of the Minister of Health, the Honourable Dr. Johnson. In his submission, on page #8, he explained to us that the Province of Manitoba discovered when they called for tenders for drugs that there were differences between the highest and lowest prices for the same drug of 491%. Would you feel that if this information and similar information were to be made available to the public, that it would be a useful supplement to the public?

that savings could be achieved through a prepaid drug plan, based on bulk purchasing and purchasing of tender



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4 calls, and that that might be an inducement to their
5 desire for such a plan?

6 DR. McINTYRE: Certainly sir, the public
7 are interested in obtaining drugs at the lowest possible
8 cost. We have some indication of this now inasmuch as
9 insofar as I know there are at least two retail drug-
10 stores in the city now who are selling prescribed drugs
11 on a straight one-dollar dispensing fee, and charging
12 the retail price or the cost price for those drugs to
13 the patient, and these drugstores, their prescription
14 drugs have accelerated tremendously since they went on
15 this particular schedule, so that, as in every other area,
16 the public are anxious to get things as cheaply as
17 possible.

18 COMMISSIONER FIRESTONE: Knowing that this
19 is desirable to the public based on this sort of experience
20 that you have pointed out, do you think that your Associa-
21 tion could perform a useful function by extending such a
22 prepaid drug plan?

23 DR. McINTYRE: Well sir, I would think that
24 the Pharmaceutical Association should come up with an
25 answer to this particular question. I believe Mr.
26 Straight can amplify it.

27 MR. STRAIGHT: I think we have to separate
28 the principle of prepayment from the cost of the drugs.
29 You can set up a device to reduce the price of the drugs
30 to the individual or group. If you reduce total cost of
the drugs to one area and you don't change the drug
industry and you go on with all the promotion, they are
going to raise the prices in some other area. If you are

calls, and that might be an inducement to their

are interested in obtaining drugs at the lowest possible cost. We have some indication of this now inasmuch as insofar as I know there are at least two retail drug stores in the city now who are selling prescribed drugs on a straight one-dollar dispensing fee, and charging the retail price on the cost price for those drugs to the patient, and these druggists, their prescription drugs have accelerated tremendously since they went on this particular schedule, so that, as in every other area, the public are anxious to get things as cheaply as possible.

is desirable to the public based on this sort of experience that you have pointed out, do you think that your Association could perform a useful function by extending such a prepaid drug plan?

the Pharmaceutical Association should come up with an answer to this particular question. I believe Mr. Straight can amplify it.

MR. STRAIGHT: I think we have to separate

the principle of payment from the cost of the drugs. You can set up a device to reduce the price of the drugs to the individual or group. If you reduce total cost of the drugs to one area and you don't change the drug industry and you go on with all the promotion, they are going to raise the prices in some other area. If you are



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4 talking about a device for drug purchasing to do something
5 for the people of Manitoba, that is one point.

6 Another point is whether the people in
7 Manitoba should prepay the drugs? Should they prepay
8 their telephone bills? Are there drugs of such a nature
9 that a whole program of prepayment of drugs is warranted
10 because there are a few that have high cost? My personal
11 view is that there has been little demand by the public
12 for prepaid drug programs. An organization of pharmacists
13 in British Columbia investigated it and decided, notwith-
14 standing the high payrolls in British Columbia and the
15 ease with which you can get a contract to pay part of the
16 contract, that it was not a necessary benefit demanded by
17 the working man, so they decided not to go into the
18 program.

19 However, I think you can isolate a few
20 specific drugs which are very expensive and use some
21 method through the hospitals or adjuncts to the hospital
22 schemes to reduce the burden without introducing a whole
23 drug program.

24 COMMISSIONER FIRESTONE: In other words,
25 you would use a select approach rather than an all-inclu-
26 sive approach to this question of reducing the cost of
27 drugs and this prepayment?

28 MR. STRAIGHT: Correct.

29 THE CHAIRMAN: Are you familiar with the
30 program at Tacoma, Washington?

MR. STRAIGHT: Well, I am familiar with the
one in Seattle. You are talking about group purchasing --
the Co-op?



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4 THE CHAIRMAN: Yes.

5 MR. STRAIGHT: Yes, I am familiar with the
6 one in Seattle, but not in Tacoma. It is a case of a
7 closed panel of doctors and subscribers and a dispensary
8 and bulk buying by generic name and educating the doctors
9 to prescribe by generic name by an agreed formula.

10 THE CHAIRMAN: And that has worked out to
11 the great advantage of the consumer, hasn't it -- the
12 figures from either Seattle or Tacoma?

13 MR. STRAIGHT: Yes, correct.

14 COMMISSIONER FIRESTONE: Dr. McIntyre, I
15 am coming to the last question. You are at the moment
16 collecting your fees in the form of a premium payment by
17 the subscribers: would you be in a position to administer
18 the scheme if the funds were collected by governments
19 through taxes and/or premiums, with your organization
20 looking after (1) the administration of the scheme, and
21 (2) ensuring that the medical profession has a major say
22 in the operations of such a plan?

23 DR. MCINTYRE: Certainly we have the admini-
24 strative machinery and the money and the know-how to
25 administer such a scheme. The second part of your ques-
26 tion is all-important, and I think that is sponsorship
27 by the medical profession. How big this would be, I am
28 not prepared to say at the moment, but our professional
29 relations have been excellent simply because -- well,
30 for various reasons -- but basically because it was
started by the medical profession. It has become their
baby, if I may call it that. They have a vital interest
in this. They are proud of the scheme. They are anxious

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4 to make it work. They have various things such as pro-
5 rating, by which they can make it work, and I am sure
6 with your vast experience in economics you will feel the
7 same way as a lot of other people do; they tell us M.M.S.
8 cannot work; it is not actuarially sound and so on and
9 so forth, and they tell us why it should not work. The
10 fact is it has worked, and is working, and it is working
11 better and better and I hope it will continue to. But it
12 is most essential that the medical profession keep behind
13 it.

14 COMMISSIONER FIRESTONE: In other words,
15 you are saying one of the secrets of your success has
16 been the close co-operation with the medical profession
17 in the Province of Manitoba, and you would hope that any
18 supplementary or expanded scheme would be able to retain
19 that co-operation?

20 DR. McINTYRE: Yes, sir.

21 THE CHAIRMAN: Dr. McIntyre, in the collec-
22 tion of your premiums, it is basically on a monthly basis,
23 isn't it?

24 DR. MacMASTER: Yes, sir.

25 THE CHAIRMAN: And that, of course, is
26 easily done where you have group subscribers?

27 DR. MacMASTER: Yes.

28 THE CHAIRMAN: Do you find it also a
29 practical thing to collect from individuals twelve times
30 a year?

DR. MacMASTER: I am sorry, I misled you.
For non-group it is on a quarterly basis. You can prepay
for six months if you wish, and the premiums are kept in

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3 suspense, but for the group business it is a monthly rate.

4 THE CHAIRMAN: I misunderstood.

5 DR. MacMASTER: The non-group is a quarterly
6 billing.

7 THE CHAIRMAN: Does M.M.S. pay any fee or
8 commission for the enrolling of subscribers -- I am
9 talking now of acquisition expense?

10 DR. MacMASTER: No, sir, with one or two
11 exceptions. In some remote areas in Manitoba, on account
12 of local problems, transportation and so forth, we allow
13 the group agent whatever items of expense are incurred --
14 postages, and so forth, and the expense of going round
15 and collecting in some of these community groups, but that
16 is purely an ad hoc arrangement.

17 THE CHAIRMAN: But you have representatives
18 in the field; do I take it they are salaried representa-
19 tives?

20 DR. MacMASTER: Oh yes, a staff on straight
21 salary; no commission.

22 THE CHAIRMAN: As far as the medical profes-
23 sion is concerned, all they get is the prorating?

24 DR. MacMASTER: Yes. The operating expense
25 is paid.

26 COMMISSIONER BALTZAN: I would like to
27 direct two or three questions to Dr. McIntyre. On page 1,
28 paragraph 8, "Doctors participating in the plan do not
29 earn 100% of the fee schedule; for example, in 1960 under
30 a prorating plan payments to medical members were 88.7%
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reading that it sometimes went as low as 88%, but that as



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4 it may. Now, that seems like a very commendable sacri-
5 fice, and I ask you, Dr. McIntyre, could these be the
6 purposes for this sacrifice: (a) to help maintain the
7 voluntary system -- a form of assistance to help maintain
8 that which interested parties are concerned with; (b) to
9 preserve the individualism that this segment is interested
10 in and (c) to encourage the public to participate and to
11 obtain certain securities by prepayment plans? Is that
12 the basis for this generosity on the part of those who
13 provide these services?

14 DR. MCINTYRE: Yes, sir.

15 COMMISSIONER BALTZAN: Dr. McIntyre,
16 reading this just out of context, could it be interpreted
17 that the fee schedule is too high if that service can be
18 rendered for only 82%?

19 DR. MCINTYRE: That certainly would not be
20 my interpretation or the interpretation of the rest of
21 the medical profession in Manitoba. The fee schedule
22 compares favourably with the fee schedules in adjacent
23 provinces and, in effect, with a few selective changes
24 there has been no overall change in our fee schedule
25 since 1949.

26 COMMISSIONER BALTZAN: Yes, which anticipates
27 my next question, Dr. McIntyre: and that is this; has
28 there been any substantial increase in the medical tariff
29 since 1949, let us say equal to the proportion of the
30 general rise of costs of other commodities and services?

DR. MCINTYRE: Did you say "medical
tariff"?

COMMISSIONER BALTZAN: Doctors' schedules



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COMMISSIONER BALDWIN: Now, what anticipated
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 there been any substantial increase in the medical bills
 since 1949, let us say equal to the proportion of the
 general rise of costs of other commodities and services?
 DR. MCINTYRE: Let me say immediately

COMMISSIONER BALDWIN: Doctors' schedules



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3 or tariff.

4 DR. McINTYRE: The only increase in the
5 fee schedule -- they are listed at the top of page 22:
6 the rates for home calls made by general practitioners
7 were raised from \$4 to \$5, and home calls \$5 to \$6 for
8 night calls and Sundays. Confinements were raised from
9 \$50 and \$75 to \$75 and \$100. The payment of surgical
10 assistance fees, there is a rearrangement in the method of
11 payment. There has been some increase in the anaesthetic
12 fees.

13 THE CHAIRMAN: What page are you reading
14 from, Doctor?

15 DR. McINTYRE: Page 22, at the top.

16 COMMISSIONER BALTZAN: Dr. McIntyre,
17 allowing for these things which you have just read, on
18 the whole would the increase be said to account for a
19 substantial rise in the cost for services rendered, and
20 is that rise comparable to the rise as we all know, feel
21 and suffer by the rise in costs of other commodities and
22 services?

23 DR. McINTYRE: No, sir. However, this has
24 been taken care of to a certain extent by the increase
25 in prorating over the years. I think Mr. Straight can
26 elaborate on this

27 MR. STRAIGHT: On page 21 of the brief in
28 paragraph 81(2) it is stated that since 1954 to 1960 the
29 proration percentage rose from 76.1 to 88.7. In terms
30 of dollars that is a 16% increase over a six-year period,
which is just over 2.1/2% a year, which goes right with
inflation to that period.

or tariff.

DR. MCINTYRE: The only increase in the fee schedule -- they are listed at the top of page 22; the rates for home calls made by general practitioners were raised from \$4 to \$5, and home calls \$5 to \$6 for night calls and Sundays. Confinements were raised from \$50 and \$75 to \$75 and \$100. The payment of surgical assistance fees, there is a rearrangement in the method of payment. There has been some increase in the anesthetic

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DR. MCINTYRE: No, sir. However, this has

been taken care of to a certain extent by the increase in proportion over the years. I think Mr. Straight can elaborate on this

MR. STRAIGHT: On page 21 of the brief in paragraph 81(2) it is stated that since 1924 to 1929 the proportion percentage rose from 78.1 to 82.7. In terms of dollars that is a 12% increase over a six-year period, which is just over 2 1/2% a year, which goes right with



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4 COMMISSIONER BALTZAN: Thank you.

5 MR. STRAIGHT: So, I would say the prora-
6 tion increase is quite acceptable for that period.

7 COMMISSIONER BALTZAN: Not knowing too
8 much about economics, can you tell me how that compares
9 with the general trend?

10 MR. STRAIGHT: I can't tell you out of my
11 head.

12 COMMISSIONER BALTZAN: I will have to find
13 that out.

14 MR. STRAIGHT: Your technical staff, I am
15 sure, will supply you with adjusted cost of living indices
16 which you can use to compare this with. I would like to
17 point out you should have available to you the annual
18 reports of the Trans-Canada Medical Plans to deal with
19 questions like that: you wanted to know about the fee
20 schedule in relation to other costs and so on, and that
21 report shows the comparison of costs in Manitoba with
22 those of other provinces. For example, we must allow for
23 the fact that in Manitoba specialists' fees are paid
24 entirely by the plan for those whose incomes are below
25 \$10,000. In the other plans specialists sometimes extra-
26 bill. In some plans they usually extra-bill for specified
27 services. But, allowing for that, here are some fair
28 comparisons. These are the high volume ones. They are
29 not isolated. These are the items which cause the cost.
30 The average cost of follow-up office business, which is
the single most important item, in Manitoba was \$2.61.
That was the average fee paid for follow-up office calls.
In British Columbia, \$3.64; Alberta, \$3.66; Saskatchewan,



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not included. I am not sure what you mean by cost.

The average cost of follow-up office visits, which is

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In British Columbia, \$3.54; Alberta, \$3.11; Saskatchewan,



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4 \$2.92 or \$2.54 depending upon the plan. So, Manitoba is
5 low on that item. On the initial office call, which is
6 not such a big volume, \$3.88 in Manitoba; \$5.08 in British
7 Columbia; \$4.67 in Alberta; \$6.38 in one plan in Saskat-
8 chewan, and \$3.80 in another, and that is a difficulty
9 of coding. Office call in Manitoba, \$4.57; British
10 Columbia, \$7.20; Alberta, \$5.39; Saskatchewan, \$4.24.
11 The cost of a normal delivery, complete confinement care,
12 \$72.50 in Manitoba; \$78.19 in one plan in British Columbia,
13 and \$81 in the other; \$67.50 in Alberta and \$56.70 in
14 Saskatchewan. You can go through this summary and see
15 that the Manitoba fee schedule on the average is below
16 that of British Columbia and Alberta, and above that of
17 Saskatchewan. So, the costs in Manitoba, if they are
18 high -- and I am not saying they are high -- but if they
19 are high for any item, it is the volume rather than price.

20 COMMISSIONER BALTZAN: This total rise of
21 16% also includes x-ray services which are more costly,
22 and includes also laboratory services which are more
23 elaborate, more frequently used and also more costly?

24 MR. STRAIGHT: The 16% increase came about
25 by reason of the proration factor on all services. Instead
26 of 77 it rose to 88.

27 COMMISSIONER BALTZAN: So it is not physi-
28 cians' cost alone; it is the ancillary services included
29 -- diagnostic services?

30 MR. STRAIGHT: You are suggesting if you
break the technical component out of the diagnostic
service?

COMMISSIONER BALTZAN: Something like that.



22.92 or \$2.84 depending upon the plan. So, Manitoba is low on that item. On the initial office call, which is not such a big volume, \$3.83 in Manitoba; \$5.08 in British Columbia, and \$4.80 in another, and that is a difficulty of coding. Office call in Manitoba, \$4.57, British Columbia, \$4.80, and \$5.08 in another. The cost of a normal delivery, complete confinement care, \$72.50 in Manitoba; \$78.70 in one plan in British Columbia and \$81 in the other. So, in Alberta and \$50.70 in Saskatchewan. You can see through this summary and see that the Manitoba fee schedule in the average is below that of British Columbia and Alberta, and above that of Saskatchewan. So, the costs in Manitoba, if they are not too high, are not too low. This total cost of the initial office call, which is not too costly, and includes also laboratory services which are more elaborate, more frequently used and also more costly. MR. STRAIGHT: The 10% increase came about by reason of the proportion factor on all services. Instead of 77 it rose to 88. COMMISSIONER BATTAN: So it is not precisely, cost alone, is it the ancillary services provided? MR. STRAIGHT: You are suggesting if you break the technical component out of the diagnostic COMMISSIONER BATTAN: Something like that.



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4 MR. STRAIGHT: That is in the charge and
5 it has arisen.

6 COMMISSIONER BALTZAN: Thank you. I have
7 one or two questions for Dr. MacMaster. I use the basis
8 for my questions to help me and to make it short, the
9 results of some neutral investigators: the Chief of the
10 Division of Public Health, Department of Health, Education
11 and Welfare of the U.S.A., and the Chief of Biometrics
12 and Social Studies of the U.S.A., but it is not about the
13 U.S.A. No. 1, Dr. MacMaster, economic barriers to medical
14 care probably existed in England and Wales before the
15 National Health Service.
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4 Now, that same barrier or barriers are
5 not exactly comparable to, say, Manitoba at the present
6 time. I am talking about the present time starting as
7 from now rather than from yesteryear. You have a good
8 deal of provision for social welfare and indigents and
9 other people who are not in a paying position that there
10 was then but there is not or is there the same barrier?
11 I think I answered my own question, there is not.

12 DR. MacMASTER: No sir, there is no
13 barrier.

14 COMMISSIONER BALTZAN: Now, the physician
15 utilization increased after the introduction of the
16 National Health Service; what was the experience here?
17 In the beginning is there a lot of utilization, does it
18 tend to decrease as time goes on or does it tend to go
19 upward?

20 DR. MacMASTER: When you speak of the
21 United Kingdom are you speaking of the care outside of
22 the hospital or care in the hospital? This is most
23 important. Do you mean in the doctor's office in the
24 United Kingdom?

25 COMMISSIONER BALTZAN: Yes, I would say
26 the care in doctors' offices utilization.

27 THE CHAIRMAN: Doctors' calls as related
28 to Manitoba

29 DR. MacMASTER: There is a utilization
30 profile here on page E2 of the appendix which indicates
the number of services per month for the years 1956 to
1960.

COMMISSIONER BALTZAN: In what way does



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4 that answer my question? Is there an increase or decrease
5 as time goes on?

6 DR. MacMASTER: It gives the picture for
7 13 specific services. Now, there are differences in
8 each type of service.

9 COMMISSIONER BALTZAN: Then I shall read
10 that later.

11 DR. MacMASTER: You notice item 6, house
12 call, the rate is going down; the office call rate is
13 going up.

14 COMMISSIONER BALTZAN: Yes, I had noticed
15 before that house calls had gone down but some other
16 things had gone up.

17 DR. MacMASTER: Yes. X-ray has gone up
18 quite a bit.

19 COMMISSIONER BALTZAN: Now, the increase
20 there cannot be compared to the same position here. Has
21 your experience here shown some trends to expand what the
22 experience there tends to show? There is no clear evi-
23 dence that the increase in physician utilization - you
24 see, you have been in operation since 1944 on not too
25 comprehensive a scale and you have been in operation since
26 1944. There they have been in operation since 1948 and
27 there is no clear indication that the increase in physician
28 utilization apparently resulting from the improvement,
29 from the National Health Service, improvement in the health
30 of the adult population. It is not certain whether the
increased physician utilization was a reflection of an
unmet health need or was merely a reflection of an unmet
demand. Have your studies to this stage shown that there

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demand. Have your studies to this stage shown that there



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4 has been an improvement amongst your subscribers in
5 general well-being and health?

6 DR. MacMASTER: Unmistakably so.

7 COMMISSIONER BALTZAN: So it was not a
8 question of an unmet demand but it was an unmet need?

9 DR. MacMASTER: Yes.

10 COMMISSIONER BALTZAN: One final thing;
11 an examination of mortality rates suggests a definite
12 improvement in the health of children in England and
13 Wales since World War II and death rates falling, for
14 the first time, below those in the United States. The
15 possibility of a favourable effect of this scheme on the
16 health of children is suggested for further exploration.
17 Have you noticed anything comparable here in the improve-
18 ment in the health and reduction of morbidity and even
19 mortality because people have recourse to this service?

20 DR. MacMASTER: Yes, sir.

21 COMMISSIONER BALTZAN: From your own
22 experience in operation since 1944?

23 DR. MacMASTER: Definitely.

24 COMMISSIONER BALTZAN: I commend you and
25 thank you.

26 MR. STRAIGHT: I was going to say in a way
27 that question is like the speech of a politician who said
28 that when he came into power the ballpoint pen was worth
29 \$17.50 and during his term of office it dropped to 55¢.
30 It is true they dropped in the United Kingdom but they
dropped elsewhere and I doubt that there is any evidence
that the Health Service caused it. If it were not that
kind of health service there would be another kind and



... ..
... ..

DR. MACMILLAN: Unmistakably so.
COMMISSIONER BARTMAN: So it was not a
question of an unmet demand but it was an unmet need?

DR. MACMILLAN: Yes.
COMMISSIONER BARTMAN: One final thing;

an examination of mortality rates suggests a definite
improvement in the health of children in England and
Wales since World War II and death rates falling for
the first time, below those in the United States. The
possibility of a favorable effect of this scheme on the
health of children is suggested for further exploration.
Have you noticed anything comparable here in the improve-
ment in the health and reduction of morbidity and even
mortality because people have response to this service?

DR. MACMILLAN: Yes, sir.
COMMISSIONER BARTMAN: From your own

experience in operation since 1949?

DR. MACMILLAN: Definitely.
COMMISSIONER BARTMAN: I commend you and

DR. STRAIGHT: I was going to say in a way
that when he came into power the defendant was worth
\$17.50 and during his term of office it dropped to six.
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dropped elsewhere and I doubt that there is any evidence
that the health service caused it. If it were not that
kind of health service there would be another kind and



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4 there is nothing to show that kind of health service
5 produces that kind of mortality.

6 COMMISSIONER BALTZAN: This is not the
7 criterion?

8 MR. STRAIGHT: Certainly not. There is
9 no telling what would have happened if there was a
10 different kind of service. For that matter it might have
11 dropped more.

12 COMMISSIONER BALTZAN: For other reasons?

13 MR. STRAIGHT: Yes. Perhaps a better
14 health plan.

15 COMMISSIONER BALTZAN: But you would admit
16 that improved medical care service is a contributing
17 factor to the improved health of people and extending
18 the life expectancy? We are concerned with improved
19 medical care service.

20 MR. STRAIGHT: I think it is platitudinous.
21 I think it should be borne in mind the demands of service
22 are not the same as need for service. People join a
23 medical care plan and the evidence shows that groups costs
24 tend to rise for two or three years, they do not rise
25 suddenly because there is a backlog of medical work to
26 be attended to, and the insurance companies believe, it
27 is because they learn to use the plan, ask the doctor to
28 come and see a sick baby and so on. That is an increase
29 in demand. A separate need for demand is a very difficult
30 thing, it is very hard to say that the existence of the
plan filled the needs that were not filled before. That
is, prepaying the service does not guarantee that you
supply more necessary or adequate services. Probably it



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3 does to some extent.

4 COMMISSIONER BALTZAN: But you would say
5 - take the example which you have just given of this
6 woman who has a sick child at home. Now that this woman
7 has prepaid her medical care service she will have no
8 hesitation in calling the doctor for help while if she
9 did not have the prepaid medical service, her husband has
10 not any money to pay for that service so she cannot call
11 the doctor. Therefore, the service you are providing is
meeting an urgent need of the people of Manitoba.

12 MR. STRAIGHT: I am talking about the
13 degree and suggesting it is a little exaggerated.

14 THE CHAIRMAN: Sometimes a child cries in
15 the middle of the night because the safety pin gets out
16 of its diaper.

17 COMMISSIONER BALTZAN: I presume you are
18 not judging the merits of the scheme on the merits of a
safety pin?

19 MR. STRAIGHT: In some medical plans they
20 stop calling the doctor in the middle of the night when
21 the safety pin sticks out.

22 THE CHAIRMAN: Have you familiarized
23 yourself with the record in Newfoundland in the last 10
24 years since the introduction of the plan there whereby
25 there is free medical service to all children up to 16
26 years of age and related to the tremendous improvement
in infant mortality and so forth?

27 MR. STRAIGHT: I have not studied or been
28 familiar with this but I know of the existence of the
29 scheme.
30



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COMMISSIONER BARTON: But you would say

-- take the example which you have just given of this woman who has a sick child at home. Now that this woman has prepaid her medical care service she will have no hesitation in calling the doctor for help while if she did not have the prepaid medical service, her husband has not any money to pay for that service so she cannot call the doctor. Therefore, the service you are providing is meeting an urgent need of the people of Manitoba.

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4 THE CHAIRMAN: Perhaps the most impressive
5 figures we have heard to date come from that one plan.

6 MR. HALL: Mr. Chairman, I have one or two
7 questions, the answer to which might assist our research
8 staff. Dr. McIntyre, was the income limit of \$10,000,
9 referred to in paragraph 10 on page 2, arbitrarily
10 selected or was there some reason for that limit?

11 DR. McINTYRE: Mr. Chairman, in answer to
12 that question, the Manitoba Medical Association set up a
13 special commission in 1956, July of 1956, and have
14 examined Manitoba Medical Service and ceilings and subscri-
15 bers and fees and so on and they deal with this income
16 ceiling of \$10,000. This is quite a long paragraph so I
17 won't read it. At that time they say from a study of the
18 various briefs submitted by the blocks of physicians in
19 Manitoba Medical Service it is apparent that the majority
20 were in favour of no income ceiling but with the privilege
21 of extra-billing to higher income groups. It must be
22 emphasized this was not a unanimous opinion. I think we
23 might file a copy of this report; I do not know if we
24 have a new one and this one is pretty beaten up but I
25 will file it.

26 THE CHAIRMAN: Well, if you can get one
27 kindly file it with Mr. Lafrance.

28 MR. HALL: My question is, how did you
29 arrive at the particular figure of \$10,000 that sets out
30 more or less the background that you read to us?

DR. McINTYRE: The historical background
is all contained in this.

MR. HALL: Was there any method or formula

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DR. MCINTYRE: The historical background

is all contained in this.

MR. HALL: Was there any method or formula



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3 to arrive at the proper level?

4 DR. McINTYRE: Not that I am aware of.

5 DR. RABSON: Mr. Chairman, I wonder if I
6 might answer that question since I sat on that Commission?
7 Our studies showed that people with an income of \$8,000
8 per year were spending as much or more than they ordinarily
9 did spend on medical care whereas people over \$8,000, the
10 premiums of Manitoba Medical Service represented less
11 than they usually spent on medical care and this justified
12 the extra-billing of people with income over \$8,000.

13 MR. HALL: On page 3, paragraph 18, sub-
14 section 5 of your submission you state:

15 "Through experience rating, service at
16 its own cost to each particular area".

17 Are you referring to geographic areas in
18 that context?

19 DR. McINTYRE: Yes.

20 MR. HALL: And have you found a difference
21 in the cost in the various geographic areas?

22 DR. McINTYRE: Yes sir, I think Dr.
23 MacMaster can amplify that.

24 DR. MacMASTER: There are differences in
25 geographic areas.

26 MR. HALL: Have you been able to relate
27 the differences in the cost to any particular factor such
28 as a mean income level in the particular areas or the
29 density of population or the availability of services or
30 anything like that?

DR. MacMASTER: Offhand I could not answer
that but we would be glad to investigate this for you.



DR. HALL: I am aware of.

DR. RABSON: Mr. Chairman, I wonder if

Our studies showed that people with an income of \$8,000 per year were spending as much or more than they ordinarily did spend on medical care whereas people over \$8,000, the premiums of Manitoba Medical Service represented less than they usually spent on medical care and this justified the extra-billing of people with income over \$8,000.

MR. HALL: On page 3, paragraph 10, sub-

section 5 of your submission you state:

"Through experience, raising, service at its own cost to each particular area".
Are you referring to geographic areas in

that context?

DR. MCINTYRE: Yes.

MR. HALL: And have you found a difference

in the cost in the various geographic areas?

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MR. HALL: I wonder if for the benefit of our research staff you would be able to give us a summary of your finding in regard to geographic rates and also in different groups?

DR. MacMASTER: Yes.

MR. HALL: And also any information you may have for the difference.

DR. MacMASTER: Certainly.

THE CHAIRMAN: Thank you very much, Dr. McIntyre and Mr. Dewar. We will now take a five-minute recess.

THE SECRETARY: The supplementary information will be Exhibit 53A.

--- EXHIBIT NO. 53A: Supplementary information re brief of Manitoba Medical Service.

--- Short Recess



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our research staff you would be able to give us a summary
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may have for the difference.

THE CHAIRMAN: Thank you very much, Dr.
McIntyre and Mr. Dewar. We will now take a five-minute

recess.

tion will be Exhibit 83A.

--- EXHIBIT NO. 83A: Supplementary information re brief
of Manitoba Medical Service.

--- Short Recess



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4 THE CHAIRMAN: We will now proceed with
5 the submission of the Manitoba Medical Association.

6 THE SECRETARY: Sir, before they start,
7 if I may, we have received a Voluntary Health Insurance
8 Survey in Canada from the Canadian Conference of Health
9 Care, which I would like to file as Exhibit No. 54.

10 --- EXHIBIT NO. 54: Voluntary Health Insurance Survey.

11
12 THE SECRETARY: Exhibit No. 55 will be
13 the main submission of the Manitoba Medical Association.

14 --- EXHIBIT NO. 55: Submission of the Manitoba Medical
15 Association.

16
17 THE SECRETARY: Exhibit No. 55A will be the
18 Supplementary Brief by that same organization.

19 --- EXHIBIT NO. 55A: Supplementary brief of the Manitoba
20 Medical Association.

21
22 THE SECRETARY: Exhibit No. 55B will be a
23 French-language version of summary and recommendations.

24 --- EXHIBIT NO. 55B: French-language version of summary
25 and recommendations of the Manitoba
26 Medical Association.
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THE CHAIRMAN: We will now proceed with

the submission of the Manitoba Medical Association.

THE SECRETARY: Sir, before they start,

if I may, we have received a Voluntary Health Insurance

Survey in Canada from the Canadian Conference of Health

Care, which I would like to file as Exhibit No. 24.

THE SECRETARY: Exhibit No. 25 will be

the main submission of the Manitoba Medical Association.

--- EXHIBIT NO. 25: Submission of the Manitoba Medical Association.

THE SECRETARY: Exhibit No. 26A will be the

Supplementary brief by that same organization.

--- EXHIBIT NO. 26A: Supplementary brief of the Manitoba

THE SECRETARY: Exhibit No. 26B will be a

French-language version of summary and recommendations.

--- EXHIBIT NO. 26B: French-language version of summary and recommendations of the Manitoba Medical Association.



SUBMISSION OF THE MANITOBA MEDICAL ASSOCIATION

Appearances: K.R. Trueman, M.D.
F.G. Allison, M.D.
L.R. Rabson, M.D.
F.W. DuVal, M.D.
R.L. Cooke, M.D.
V.J.H. Sharpe, M.D.
M.A. Sirett, M.D.
A.R. Tanner, M.D.
M.T. Macfarland, M.D.
R.P.H. Sprague, Esq.
Adviser: A.D. Kelly, M.D.

THE CHAIRMAN: Dr. Trueman, you are the
spokesman for your group this morning?

DR. TRUEMAN: That is right, Mr. Chairman.
Mr. Chairman and members of the Royal Commission, it
gives me pleasure to introduce to you a number of my
colleagues who will participate in discussion as they
follow.

THE CHAIRMAN: If you will proceed, Dr.
Trueman.

DR. TRUEMAN: Mr. Chairman and members of
the Royal Commission, the Manitoba Medical Association
also wishes to take the opportunity to welcome the
Commission on Health Services to Manitoba.

SUMMARY AND RECOMMENDATIONS

The Manitoba Medical Association welcomes
the Royal Commission on Health Services to Manitoba.

The following is a summary and recommenda-
tions of the submission by the Manitoba Medical Association
to the Royal Commission on Health Services. The brief
contains an index of the material studied. It will be
noted that we have taken some liberty in considering
together terms of reference (a), (d) and (e), which are
then discussed in (b) and (c). There is also included a

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4 map with some data revealing the distribution of the popu-
5 lation and the position of key medical centres in the pro-
6 vince.

7 In our brief, sir, we say that the training
8 and motivation of the physician, his responsibilities and
9 his need for independence in his approach to matters of
10 greatest consequence, health and sickness of the patient,
11 create a position that is unique in the community.
12 Whatever interferes with this in the form of outside
13 factors may be harmful.

14 On the other hand we have sought to intro-
15 duce methods of self-discipline other than those referred
16 to in Appendix "C", have been developed by the profession
17 as follows:

- 18 1. Admission and Discharge Committees
19 of Hospital Staffs; to facilitate the
20 patients' movements into and out of
21 hospitals;
- 22 2. Credentials Committees in hospitals
23 to regulate privileges according to compe-
24 tence;
- 25 3. Tissue Committees to study operative
26 results in hospitals, both urban and rural;
- 27 4. Medical Review Committee of Manitoba
28 Medical Service.

29 And finally the Fee Taxing Committee of
30 the College of Physicians and Surgeons, which is used
occasionally, and depends on the basis of complaints from
patients.

Restrictions imposed by outside bodies



map with some data revealing the distribution of the population and the position of key medical centres in the province.

In our brief, sir, we say that the training and motivation of the physician, his responsibilities and his need for independence in his approach to matters of greatest consequence, health and sickness of the patient, create a position that is unique in the community. Whatever interferes with this in the form of outside factors may be harmful.

On the other hand we have sought to introduce methods of self-discipline other than those referred to in Appendix "C", have been developed by the profession as follows:

1. Admission and Discharge Committees of Hospital Staffs; to facilitate the patients' movement into and out of
 2. Credentials Committees in hospitals to regulate privileges according to competence;
 3. License Committees to study operative results in hospitals, both urban and rural;
 4. Medical Review Committee of Manitoba and finally the Fee Fixing Committee of
- Restrictions imposed by outside bodies



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3 which interfere with the professional component of
4 medical care will adversely affect the quality of care.

5 These ideas are well known and especially
6 to the members of the Royal Commission. However, they
7 are set down here inasmuch as they are foundation stones
8 related to the great bulk of medical services received
9 by the people through the practice of medicine.

10 We feel that they must be examined in any
11 study directed towards the health services of a community.
12 Furthermore, at this juncture I think we would emphasize
13 that matters such as slum clearance, housing and nutrition
14 are high priorities and are the bases of any good health
15 program.

16 At this point, sir, I would like to reveal
17 some real needs existing in welfare areas. These needs
18 represent an important priority. That they have been
19 allowed to flourish is a plague on our society, far
20 surpassing apparent defects in the provision of medical
21 services, and I think, sir, that a short review of the
22 problem indicates its extent in the City of Winnipeg in
23 the matter of housing. Although I thought possibly this
24 information would have been brought to you in other
25 presentations, I feel that since it has not been some
26 representation of this situation should be included in
27 the records of your attendance here. For instance, in
28 Winnipeg there are 10,000 people living in slum and
29 near-slum conditions. In one small area of three acres
30 there are some 1,600 people living, of whom 825 are
children under the age of 16 years. They are living in
what has been described by investigators as shockingly



which interfere with the professional component of medical care will adversely affect the quality of care. These ideas are well known and especially

to the members of the Royal Commission. However, they are set down here inasmuch as they are foundation stones related to the great bulk of medical services received by the people through the practice of medicine.

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At this point, sir, I would like to reveal some real needs existing in welfare areas. These needs represent an important priority. That they have been allowed to flourish is a plague on our society, far surpassing apparent dangers in the provision of medical services, and I think, sir, that a short review of the problem indicates its extent in the City of Winnipeg in the matter of housing. Although I thought possibly this information would have been brought to you in other presentations, I feel that since it has not been some representation of this situation should be included in the records of your attendance here. For instance, in Winnipeg there are 10,000 people living in slum and near-slum conditions. In one small area of three acres there are some 1,600 people living, of whom 812 are children under the age of 16 years. They are living in what has been described by investigators as shockingly



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3 unsanitary conditions. And many of their elders have
4 lived there before them. Information, sir, is available
5 as to the number of very poor and poor conditions of
6 dwelling units in Winnipeg. It has been indicated that
7 6,500 residences have no running water, that there are
8 18,000 without the exclusive use of a flush toilet, that
9 many have no bathroom or shower, or even a hand basin.
10 If this exists, sir, then what must be the diets and
11 clothing supplies of the people who dwell in these areas?

12 It has been suggested and recommended that
13 700 new housing units are needed to relieve these
14 unhealthy living conditions as they exist, and a 10-year
15 plan for the eradication of slum areas indicates a total
16 cost of \$15,000,000. No matter when this starts, for
17 another 10 years some of the people involved will be
18 subjected to these conditions. The Federal Government
19 has agreed to cover a great part of the cost, and the
20 City of Winnipeg will cover part of the cost, and the
21 Provincial Government will cover part of the cost.

22 The point I am trying to make, sir, is
23 that this condition actually exists at the present time,
24 and it will be years before any correction follows. We
25 urge action in this area of slum clearance as a measure
26 in preventive medicine, and we feel it represents a more
27 intelligent approach than treatment of ills among these
28 people, and then sending them back to these unsanitary
29 living conditions.

30 We should keep in mind that poverty breeds
poverty, just as success breeds success. Many of these
people of 16 years and older are coming to accept this as



unsanitary conditions. And many of their elders have lived there before them. Information, sir, is available

as to the number of very poor and poor conditions of dwelling units in Winnipeg. It has been indicated that 6,500 residences have no running water, that there are 18,000 without the exclusive use of a flush toilet, that many have no bathroom or shower, or even a hand basin.

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3 a fact of life. Those who are interested indicate that
4 they are concerned about the cost of correcting this
5 serious situation.

6 These matters, sir, are mentioned in the
7 Social Allowances Act of 1959, but as I say they have
8 existed long before the Act was passed, and obviously
9 such matters have an important bearing in the health
10 and the moral development of our people. Here is where
11 there is a breeding ground for what the Government has
12 described as second-class citizens.

13 These matters are as important, certainly,
14 as pension and other political manoeuvres. Through the
15 eyes of this Commission, Government may receive a new
16 look at what is shameful in Canada.

17 Now, Mr. Chairman, I would like to turn
18 back to the summary and follow it.

19 The production of this submission to the
20 Royal Commission has impressed us with the diversity and
21 wide extent of health services in which many bodies --
22 the profession, government and the voluntary agencies --
23 participate. We are proud of the efforts and results of
24 their activities. There are a number of matters however
25 which require attention. To a degree they are related
26 but all require special mention.

27 1. The need for medical and para-medical
28 personnel.

29 (a) Physicians. Despite the favourable
30 doctor population ratio of 1:879, the number of doctors
is not enough to meet all requirements. There are suffi-
cient general practitioners and specialists in most fields.

a fact of life. Those who are interested indicate that they are concerned about the cost of conducting this serious situation.

These matters, sir, are mentioned in the Social Allowances Act of 1958, but as I say they have existed long before the Act was passed, and obviously such matters have an important bearing in the health and the moral development of our people. Here is where there is a pressing ground for what the Government has described as second-class citizens.

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1. The need for medical and para-medical personnel.

(a) Physicians. Despite the favourable doctor population ratio of 1:379, the number of doctors is not enough to meet all requirements. There are suffi-



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4 There is a need for additional psychiatrists, radiolo-
5 gists and pathologists and doctors in the field of preven-
6 tive medicine.

7 The satisfactory ratio mentioned depends
8 very greatly on the large number of foreign registrants
9 in Manitoba. This supply can be affected any time.
10 Furthermore, there is an increase in population antici-
11 pated for this province. Therefore efforts must be
12 pursued to enlarge the enrollment in medical school. The
13 University authorities declare the facilities of the
14 school will absorb an additional 40 per cent of students.
15 Doctors and others could do much to interest high school
16 and University students in the profession of medicine.
17 Government should be urged to make the cost of all higher
18 education (perhaps beyond the bachelor degree), income
19 tax deductible whereupon students would be encouraged to
20 pursue higher education in using loan funds.

21 (b) Para-medical personnel. It has been
22 shown by the Minister of Health yesterday and in our main
23 brief, that facilities for training are satisfactory and
24 are being increased.

25 1) Physiotherapists and occupational
26 therapists are trained in the school established at the
27 Medical College two years ago. Their further instruction
28 will be carried on at the Rehabilitation Hospital in
29 Winnipeg.

30 2) Radiographers and laboratory technicians
also have proper training facilities. These will be
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There is a need for additional psychiatrists, radiologists and pathologists and doctors in the field of prevention.

The satisfactory ratio mentioned depends very greatly on the large number of foreign registrants in Manitoba. This supply can be affected any time. Furthermore, there is an increase in population anticipated for this province. Therefore efforts must be pursued to enlarge the enrollment in medical school. The University authorities desire the facilities of the school will absorb an additional 40 per cent of students. Doctors and others could do much to interest high school and University students in the profession of medicine. Government should be urged to make the cost of all higher education (perhaps beyond the bachelor degree), income tax deductible whereupon students would be encouraged to pursue higher education in using loan funds.

(b) Para-medical personnel. It has been shown by the Minister of Health yesterday and in our main brief, that facilities for training are satisfactory and are being increased.

(c) Physiotherapists and occupational therapists are trained in the school established at the Medical College two years ago. Their further instruction will be carried on at the Rehabilitation Hospital in Winnipeg.

(d) Radiographers and laboratory technicians also have proper training facilities. These will be established later in the Manitoba Institute of Technology now being built by Government.



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4 2. Mental illness. This is a vast and
5 complex problem which appears to be yielding to the
6 availability of new medications as well as the established
7 therapeutic measures. The effect of this is the advocacy
8 of a new program. This envisages the decentralization
9 of facilities in order to establish others in a number of
10 places in the province so that patients would be nearer
11 their homes and families and their care would be shared
12 by their own doctor. Psychiatrists and para-psychiatric
13 personnel are urgently needed and without their presence
14 a program of great benefit to many in the community may
15 never be fulfilled. The psychiatrists can only be trained
16 as they complete their medical education. Therefore this
17 problem is largely dependent upon enrollment of medical
18 students. Recent graduates would require several years
19 of training and experience. This is one area where
20 federal grants have been available and have facilitated
21 greatly the training of psychiatrists.

22 Mr. Chairman, a separate brief, included
23 as it is in the main brief of the Association for
24 completeness, will be presented later by Dr. Pincock.

25 3. Voluntary Prepaid Insurance for
26 Medical Service. In this matter the medical profession
27 advocates a plan for medical services coverage which will
28 provide for those who cannot pay, and permit those able to
29 insure themselves the right to do so voluntarily, and
30 this will be enlarged upon presently in our supplementary
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31 This is a simple philosophy which is the
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4 of medicine. To support this philosophy the doctors of
5 Manitoba have created and sponsored the Manitoba Medical
6 Service. This is a non-profit service plan. It insures
7 in an adequate or comprehensive manner all services which
8 doctors themselves provide. As a service plan there are
9 no extra charges, except extra-billing by the doctor
10 himself for the few high income subscribers who may earn
11 more than \$10,000 annually. There are no deterrent or
12 co-insurance features. Pre-existing conditions are
13 included without waiting periods. Preventive services
14 such as annual examinations and immunization, infants
15 and children's check-ups, are paid for. Payment of
16 services for mental illness and care of chronic ailments
17 in or out of hospital are also met. Age does not repre-
18 sent a restriction nor does a subscriber require to be a
19 member of a group. These benefits answer the criticism
20 from certain quarters that voluntary prepaid medical
21 plans are incomplete or abound in restrictions.

22 The profession feels the extension of
23 these services to those who need help to obtain them is
24 indicated and urges government to undertake them. In
25 doing so the profession believes the Manitoba Medical
26 Service meets the responsibilities of this coverage in
27 an efficient and economical manner as evidenced by its
28 record of of satisfaction to its subscribers.

29 4. Our studies have shown that the physical
30 facilities for the provision of preventive, diagnostic,
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4 needed and in this connection the report of the Manitoba
5 Hospital Survey Board which contains most of the pertinent
6 information, is endorsed in principle by this Association.

7 These and other problems represent priori-
8 ties requiring attention by enlightened governments at
9 the federal and provincial levels. The great need is
10 money for building, services, and the personnel to run
11 them. If the money is available the matters can be
12 resolved. We feel it should be used wisely and from one
13 stage to another until Canada is proud to reveal her show-
14 case of medical and other health services as examples of
15 what can be achieved by government and private enterprise
16 in a system which recognizes the natural and proper
17 spheres which each should occupy.

18 In conclusion the Manitoba Medical Associa-
19 tion recommends;

20 1. That the medical profession of Manitoba
21 working with interested parties, continue development of
22 voluntary prepaid medical care, since this method has
23 proved such a success in the past.

24 2. That comprehensive medical services on
25 a prepaid basis available at present in Manitoba, be
26 supplied to all those who cannot pay for them, through
27 government subsidization.

28 3. That the fee-for-service method of remunera-
29 tion is superior to other methods of providing personal
30 medical care. However, in certain circumstances other
methods or a combination of methods are necessary as
exists at present.

 4. That the program for mental diseases



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4 as outlined by the Psychiatric Section of the Manitoba
5 Medical Association and approved in principle by the
6 Association, be implemented as early as practicable.

7 5. That methods be developed to increase
8 enrollment of medical students at the University of Mani-
9 toba through the efforts of the University and the Asso-
10 ciation, and through financial assistance to worthy
11 candidates in order to meet the present and future needs
12 of the province.

13 6. That recruitment of technicians for
14 radiology and pathology be sponsored so as to attract
15 individuals on a permanent basis to these fields.

16 7. That the report of the Manitoba Hospital
17 Survey Board in relation to the future bed requirements
18 of both acute and chronic nature, be implemented.

19 8. That a program for the provision of
20 alternate care accommodation in Manitoba be implemented,
21 in order to facilitate the discharge of patients from
22 active and chronic care hospitals.

23 9. That funds for research and post-
24 graduate medical training in hospitals be provided through
25 University funds and not be included in the budget of the
26 hospital.

27 10. That the system of part-time teachers
28 in the medical school and open hospitals be continued as
29 this produces a high level of medical competence with
30 benefit to the patients, students and doctors.

11. That sales tax on drugs be abolished
together with tariffs on appliances and prostheses not
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4 12. That health insurance premiums be an
5 income tax deductible item.

6 Mr. Chairman, this is more or less a foot
7 in the door, which I will describe. With the final
8 recommendation we wish to introduce the Doctors' Plan
9 for the insuring of medical care costs with special
10 reference to the indigent, and the marginal income indi-
11 vidual, who may need assistance in providing this insurance.
12 This is the study of our supplementary brief, which will
13 be presented to you by Dr. Rabson, and with him, as I
14 said, will be Professor Clarence Barber to supplement
15 the information which that brief contains.

16 Dr. Barber's researches in this matter
17 have led us to develop a practical and economical plan,
18 reflecting the areas of need in this province and the
19 social obligations of the citizens, and the interest of
20 our profession.
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7 insurance. When this plan is adopted in Manitoba, there
8 would then be universally available here the highest
9 standard of medical care for all segments of the popula-
10 tion, in keeping with the beliefs and principles of the
Canadian Medical Association.

11 We advocate that universally-available
12 medical services should be comprehensive in scope. By
13 comprehensive medical services we mean all those medical
14 services - preventive, diagnostic, therapeutic and rehabi-
15 litative - rendered by qualified doctors in all branches
16 of medicine. The voluntary non-profit plan, Manitoba
17 Medical Service, sponsored and subsidized by the doctors
18 of Manitoba offers truly comprehensive medical services
19 insurance. It is available to all persons regardless of
20 age or state of health. Our proposed plan will make it
21 available to all regardless of financial status. It can
22 be done efficiently and at proven low administrative cost
on such a voluntary basis. We hope other carriers will
compete in this field.

23 The Manitoba Medical Association supports
24 the proposition that those persons able to provide for
25 themselves should do so in keeping with the philosophy of
26 our Canadian society. We also support the concept of
27 community responsibility for those requiring financial
28 assistance. We believe that the acquisition of medical
29 services is and must remain primarily a personal responsi-
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3 shelter and the other necessities of life. Just as in
4 the case of these other essentials the community as a
5 whole has set up mechanisms for their acquisition by
6 those unable to obtain them for themselves, so do we
7 recommend the establishment of mechanisms for the acqui-
8 sition of medical services for those unable to obtain
9 such services or insurance coverage for themselves.

10 I would like to say, Mr. Chairman, that
11 yesterday in discussing the people who didn't have
12 medical services coverage, it was said that a great
13 number could not afford the premiums, or would have diffi-
14 culty in meeting the premiums. I would suggest there
15 are a great many who have difficulty in buying food and
16 paying rent, and yet as long as they are not on welfare
17 they manage to do so, and no suggestion has been made to
18 develop means whereby all food should be subsidized, or
19 to make it equally available to all people at the same
20 price.

21 We find the view of certain extremists
22 that medical services insurance should be supplied under
23 complete government control, direction and finance, as
24 unacceptable as we would find the proposition of a govern-
25 ment monopoly in the supply of food, clothing and shelter.
26 This becomes more unreasonable when at the present time
27 medical care can be budgeted for and paid for at a reason-
28 able cost through the mechanism of prepaid insurance.
29 However, where need can be anticipated or demonstrated
30 we would advocate community help through a subsidy
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3 of remuneration to doctors affects the quality of medical
4 care (reference M.M.A. Brief, Page 10, Paras. 24-32
5 inclusive), and we also contend that the source of funds
6 affects the quality of care. If funds come entirely from
7 a central authority which of necessity then exercises
8 complete control over the providers of medical care, the
9 quality of care declines. (Reference "Hospital & Medical
10 Economics", University of Michigan Study).

11 "Cost, quantity and quality are inevitably
12 intertwined, and any control pattern must adequately
13 consider the reciprocal effects of each. It is especially
14 important to recognize that control of cost or quantity
15 without reference to quality standards is apt to be
16 ineffective or even harmful.

17 Insofar as possible, direct control upon
18 cost, quantity or quality of care should be exercised
19 only by the providers of care. Whenever the providers of
20 care can reasonably be expected to have the capacity to
21 exercise direct control, other agencies should utilize
22 only indirect control.

23 Insofar as possible, professional control
24 is preferable to financial or legal control. Not only is
25 professional control more palatable, but also it recog-
26 nizes two important facts:

- 27 1. That in the final analysis the provi-
28 ders of care must make the decisions and
29 implement the programs which determine
30 cost, quantity and quality of care;
- 31 2. That proper application of professional
32 control offers the greatest opportunity for



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6 We wish to amplify the above quotation
7 regarding the control of cost, quantity and quality of
8 medical care. In our free enterprise competitive society
9 the consumers, as well as the providers, do now and
10 should continue to exercise control on cost, quantity and
11 quality of medical care. Every day citizens now make
12 decisions to seek or not to seek their own medical care
13 which decisions exercise continuing control of cost,
14 quantity and quality of medical care. We believe that
15 these free decisions are a democratic right and constitute
16 an adaptable, sensitive and rapid control mechanism, truly
17 representing the wishes of the citizens.

18 THE ACQUISITION OF MEDICAL SERVICES INSURANCE

19 In the acquisition of medical services
20 insurance our population can be classified into four
21 groups:

- 22 1. Those who are self-supporting and can
23 afford medical services insurance of any
24 type (service or indemnity) or who can pay
25 for their health care bills themselves.
- 26 2. Those who are self-supporting but can
27 afford only comprehensive medical services
28 insurance since it would be impractical for
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3. Those who may be self-supporting but
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4 (In this group are those people who pay no
5 income tax and who are not receiving social
6 assistance or welfare).

7 4. Those who are not self-supporting and
8 are already receiving public assistance
9 for the other necessities of life.

10 It is with groups 3 and 4 that we are
11 particular concerned.

12 One practical approach to the problem of
13 arranging medical services insurance for the latter two
14 groups is through the plan which we now propose for govern-
15 ment subsidy of these groups. Under our proposed plan
16 categories 3 and 4 would receive government subsidy -
17 being total for those in group 4 and at various rates as
18 income levels rise for category 3.

19 In other words, we are attempting to build
20 an economic bridge for those who on the basis of our
21 study we anticipate would require help in purchasing
22 comprehensive medical services insurance. Thus it becomes
23 important to identify those people whose needs are met and
24 financed inadequately or not at all.

25 ACCREDITATION BOARD

26 Having identified those persons requiring
27 help (see below), how do we ensure proper plans for their
28 coverage?

29 A fundamental requirement of this proposed
30 plan is the establishment of an Accreditation Board for
31 subsidized prepaid medical care plans. This Board must
32 operate independently but would consist of representatives
33 of the public, the government, the medical profession, as

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4 tation for any plan would be based on:

5 1. The type of coverage offered (there
6 would be no approval for plans offering
7 coverage unsuitable for the income groups
8 under consideration).

9 2. The premiums charged for types of
10 coverage and the return to the subscriber
11 as compared to the premium.

12 3. Accreditation would require carriers
13 to supply non-cancellable contracts for
14 those subsidized.

15 Only accredited plans would be eligible
16 for government subsidy.

17 The doctor-sponsored plan seeks no monopoly
18 in this field. The presence of other carriers and plans
19 fulfills our belief that competition for the supply of
20 medical services insurance is as important a principle as
21 competition is for the provision of other goods and ser-
22 vices. Efficiency, economy and a high state of excellence
23 are the result of competition. Professor Lees, an econo-
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25 "In the first place, preferences are
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11 tion".

12 Accreditation of plans would safeguard the
13 public interest and allow plans to be offered to various
14 income groups that would be entirely suitable for those
15 groups with free choice available.

16 Furthermore, if you accept our recommenda-
17 tions, as we think you should do, (incidentally, Mr.
18 Chairman, Mr. Roblin said yesterday you would be hearing
19 from the doctors and that the doctors may be right or may
20 be wrong. I would like to suggest to you and your
21 Commissioners, sir, that for your peace of mind and the
22 peace of mind of our citizens you will have to assume
23 that mostly we are right) it is our opinion that the
24 sharing of costs between the various levels of government
25 should be a matter for study by and a finding of this
26 Commission.

27 IDENTIFICATION OF THOSE REQUIRING ASSISTANCE

28 In Manitoba the Medicare program is avai-
29 lable to the Social Assistance group by partnership
30 between the government and the medical profession. Subsidy
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We have previously advocated the extension of this plan
to include a total of 43,000 persons (all those for whom



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hospital premiums are now waived). Reference M.M.A. Brief, Page 163, Para. 547 and Page 179, Para. 593, Table B.

Who else requires assistance in buying comprehensive medical care insurance in Manitoba?

In order to establish an income range within which some element of government subsidy would seem indicated, the Manitoba Medical Association in 1960 asked Clarence L. Barber, Professor of Economics and Sociology, The University of Manitoba, to prepare a study of minimum family earnings required to cover basic living costs, given the accepted standards and attitudes of this country. Details as to the basis on which these estimates were prepared are given in the Appendix to this supplementary brief, Table I. The data presented are for urban residents of Manitoba.

Quoting from this Appendix prepared by Professor Barber, he has reached the following conclusions:

"These data suggest that individuals and families in urban areas of Manitoba whose incomes are below the following levels, require some subsidization in meeting the costs of comprehensive medical care, e.g.:

The total incomes of families are mentioned.

1 Adult - \$1,400

2 Adults - 2,000

2 Adults &
2 Children - 2,800

2 Adults &
5 Children - 3,700

Since living costs in rural areas and

hospital premiums are now waived). Reference M.M.A.
Brief, Page 163, Para. 247 and Page 179, Para. 292,
Table B.

Who else requires assistance in paying

comprehensive medical care insurance in Manitoba?

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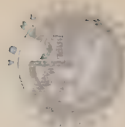
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4 smaller towns are usually lower than in
5 larger urban centres; any plan of subsi-
6 dies which is based on the above scale of
7 incomes would also adequately cover the
8 needs of people who live outside of the
9 larger urban centres".

10 Under the plan which is proposed, maximum
11 income levels at which families and individuals would be
12 eligible for subsidies are at or below income exemptions
13 presently allowed for personal income taxes. In other
14 words, they are families or individuals whose incomes are
15 so low that they are not required to contribute taxes out
16 of their income directly to the cost of government service
17 despite the fact that they are in the main able to support
18 themselves.

19 Because the personal income tax is based
20 directly on the ability to pay, we feel it to be inconsis-
21 tent to argue that individuals and families falling into
22 this "ability-to-pay" category should at the same time
23 receive a subsidy towards the cost of their medical care.
24 This decision as to "ability-to-pay" has already been
25 made by government.

26 Maximum income levels eligible for subsidy
27 also correspond closely to the minimum budget levels
28 below which it is suggested (Table I, Appendix) some subsi-
29 dization of medical care insurance is required.

30 Based on the current group premium for
individuals under the Manitoba Medical Service, we have
prepared the following plan for subsidization of prepaid
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income levels:

I will not read the table, Mr. Chairman, but the point is that below certain income levels people receive total subsidy and at certain other levels they would get a subsidy at which their medical service insurance would cost approximately \$3 a month. The next higher income group would get a subsidy which would make their premiums about \$6 a month.

TABLE A

A Set of Subsidies for Financing the Cost of Prepaid Comprehensive Medical Care

Scale of Subsidy (Per annum)	FAMILIES				
	Income Level at which Subsidy Applies by				
	Size of Family				
	2 Adults	2A & 1C	2A & 2C	2A & 3C	2A & 4C
\$108 (100%)	Under \$1000	Under \$1300	Under \$1600	Under \$1900	Under \$2200
\$72	\$1000-1499	\$1300-1799	\$1600-2099	\$1900-2399	\$2200-2699
\$36	\$1500-1999	\$1800-2299	\$2100-2599	\$2400-2849	\$2700-3099
Nil	\$2000 & over	\$2300 & over	\$2600 & over	\$2850 & over	\$3100 & over

INDIVIDUALS

\$43.20 (100%)	Under \$700
\$20.00	\$700 - \$1099
Nil	\$1100 and over

The cost of implementing the above set of subsidies in the Province of Manitoba as of 1961 is estimated to amount to about \$5.3 million. This estimate excludes the cost of providing for those families and individuals whose medical care is currently provided under our recommendations for the Medicare program. That

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A set of Subsidies for Financing the Cost of Prepaid Comprehensive Medical Care

Scale of Subsidy (Per annum)	Income Level at which Subsidy Applies by Size of Family				
	2 Adults	3 Adults	4 Adults	5 Adults	6 Adults
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\$72	\$1000-1499	\$1300-1799	\$1600-2099	\$1900-2399	\$2200-2699
	1999	1799	2099	2399	2699
	1999	2099	2399	2699	3099
\$41	\$2000-2999	\$2300-2999	\$2600-2999	\$2900-2999	\$3200-2999
	2999	2999	2999	2999	2999
	\$ over	\$ over	\$ over	\$ over	\$ over

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figure of 1,700,000 would make a total of approximately \$7,000,000. This estimated cost is broken down as follows:

	<u>Number receiving Subsidy</u>	<u>Amount of Subsidy</u>
Families	54,000	\$4.2 million
Individuals	37,000	\$1.1 million

Under this plan at least 25 percent of all families and 22 percent of single individuals would receive some subsidy towards the cost of their medical care.

It is an interesting fact that on a study across Canada, on the average about 25% of people in Canada do not pay income tax.

APPLICATION OF SUBSIDY

How is this subsidy to be arranged so that it preserves the principle of voluntary enrollment and the principle of helping those who need help?

The Provincial Government through its agency - either Health Department or Welfare Department - would conclude arrangements with accredited plan carriers for the income groups involved (obviously we are considering only comprehensive medical services). Based on the projected figures such as we have supplied here and subject to modification acquired by experience, regular payments could be made to accredited carriers on a retention-experience basis. This has already been done under the Medicare plan where additional payments to, or refunds from Manitoba Medical Service will be made to the Provincial Government after an arranged time interval.

Both the Federal and Provincial Governments can identify with ease those persons not required to pay



figure of 1,700,000 would make a total of approximately \$7,000,000. This estimated cost is broken down as

Number receiving Subsidy		Amount of Subsidy
Families	24,000	\$4.2 million
Individuals	37,000	\$1.1 million

Under this plan at least 25 percent of all families and 32 percent of single individuals would receive some subsidy towards the cost of their medical care.

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5 obtain proof of income.

6 Carriers would charge a group rate premium
7 consistent with the subsidy determined by the individual's
8 financial status, reference Table A, and would bill govern-
9 ment for the total amount of subsidy of those on their
10 rolls. Employer contribution would not be affected by
11 this subsidy but the persons involved would benefit from
12 the subsidy. Municipal enrollment under this plan would
13 become attractive and facile.

14 The plans identified by the Accreditation
15 Board and accepted by the Department of Government
16 because of their accreditation, have the administrative
17 machinery to handle this situation.

18 The argument may be made that our proposed
19 plan does not ensure enrollment of some of the people
20 needing coverage. We believe that total payment of
21 premiums for some and subsidized premiums for others will
22 encourage the vast majority of citizens involved to
23 enroll. Lees, "Health through Choice", states:

24 "This mistrust of freedom of choice under-
25 lies the idea that, if people are left to
26 buy medical services like other commodities,
27 they will not buy as much as they 'ought'
28 to do. On this view, medical care would
29 be more plentiful if supplied free by the
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5 and their children that they would behave,
6 if left free to do so, as if medical care
7 were unimportant. It is true that some
8 parents do not make what the majority
9 regard as proper choices for their children,
10 even though they have sufficient money.
11 But in a society which treats the family
12 as the fundamental social unit, these
13 cases are better dealt with by general
14 laws for the protection of children and
15 not by free services which suppose that
16 most parents would otherwise neglect their
17 responsibilities. On empirical grounds,
18 as we shall show later, there are good
19 reasons for supposing that individuals,
20 if left to their own free choice, would
21 have spent more on medical services than
22 public authorities have done". (This was
23 in connection with the British National
24 Health Scheme.) "Twenty years of sharply
25 rising public expenditure have tended to
26 obscure the fact that governments can be
27 mean as well as generous".

28 I should like to point out in that connec-
29 tion that in this country the Federal Government spends
30 over \$500,000,000 on family allowances which it gives to
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mation that for the most part they do.



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3 THE CHAIRMAN: There are some controls.

4 DR. RABSON: Not directly, sir.

5 THE CHAIRMAN: If children don't go to
6 school, the allowance is cut off.

7 DR. RABSON: But this has nothing to do
8 with the use of the money. The other thing is, in this
9 province the Federal Government puts \$24,000,000 in the
10 hands of 135,000 families and has no control over how
11 the money is spent. They trust to the judgment of the
12 people.

13 The medical profession now treats and
14 will continue to treat all citizens seeking care. If
15 persons are found without coverage to which they are
16 entitled, the doctors involved will treat the patient and
17 notify the appropriate agencies and coverage will be
18 provided.

19 Education of the public regarding the
20 need for medical services insurance is a responsibility
21 of both the medical profession and the government.

22 The extension of other health services
23 along these lines will be studied as time proceeds and
24 as experience and evolution demonstrate the course which
25 seems best suited for such provision.

26 We strongly urge that the basic issue
27 presented here is that available funds for the provision
28 of comprehensive medical services insurance be directed
29 to those who require help rather than using such funds for
30 people quite able to look after themselves.

I don't propose to read the appendix, Mr.
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THE CHAIRMAN: Thank you very much. It is
now twenty minutes past twelve and I think it is a good
time to adjourn for lunch. We will meet again at 2
o'clock.

--- Luncheon adjournment.

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4 --- On resuming at 2 p.m.

5 THE CHAIRMAN: Have you any further
6 submissions to make, Dr. Trueman or Dr. Rabson?

7 DR. TRUEMAN: No, we are through, sir.

8 THE CHAIRMAN: Fortified and ready for
9 the questions?

10 DR. RABSON: I would like to possibly
11 summarize what we are trying to say and particularly
12 dealing with Dr. Trueman's description of the great need
13 in the field of housing and shelter and our desire to
14 have those people who need to be covered to be covered.
15 We feel this creates a situation which we think makes
16 our plan the most feasible. We feel if an attempt is
17 made to make the benefits of medical service insurance
18 equal for everybody that money will be diverted and that
19 the fundamental requirement of health service will be
20 neglected. There is, after all, only so much money. I
21 think the members of the Government yesterday said: "How
22 much shall we spend? How much of the gross national
23 product should be allotted?" There is only so much can
24 be allotted so that the people who need things, and
25 really need things will not be neglected. It is not only
26 health care, there are many other things and Dr. Trueman's
27 description of the housing situation emphasizes this.

28 THE CHAIRMAN: Well now, Dr. Trueman, just
29 following along in that line on the assumption that some
30 such program as that advocated by Premier Roblin yesterday
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3 provided and accepting that the Manitoba Medical Associa-
4 tion controls Manitoba Medical, we start with that
5 proposition; you brought it into being and it is your
6 instrument, as I understand it; is that right?

7 DR. TRUEMAN: That is correct, sir.

8 THE CHAIRMAN: Would the medical profession
9 in Manitoba see any real obstacle to having the vehicle,
10 if Manitoba Medical was chosen, cover other services
11 such as dentistry, drugs or any other health service such
12 as chiropracty and that kind of thing?

13 DR. TRUEMAN: Mr. Chairman, as you
14 remember the plan which the Premier presented to you
15 yesterday was lacking in certain details and information
16 which would make it difficult, I think, for the Commission
17 or for ourselves, to discuss. It would be difficult for
18 me to make any suggestions as to the reaction of the
19 Manitoba Medical Association as to the suggested use the
20 Premier made of the Manitoba Medical Service as a vehicle
21 or medium for the provision of the services, of the
22 insurance services. I regard it as a high compliment
23 that he should have suggested so frequently that the
24 Manitoba Medical Service had achieved this position in
25 its ability to do this piece of work for the community.

26 However, I could not be sure from the
27 Premier's remarks that he had been considering that simi-
28 lar insuring bodies could not do the job just as well.
29 If you wish me to enlarge on this you must accept that I
30 am speaking not as the President of the Manitoba Medical
Association but as somebody whom you have asked to
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4 THE CHAIRMAN: No, I think we would like
5 to get the views of the Manitoba Medical Association if
6 we can.

7 DR. TRUEMAN: Well, I will qualify anything
8 I say by recalling to you that the details of the plan
9 were very sparse and even under close examination by
10 members of the Commission the Premier did not divulge
11 all the matters which would require proper understanding.

12 THE CHAIRMAN: Perhaps I did not phrase
13 my question correctly. In your supplementary brief this
14 morning you bring forward a plan which is not complete
15 in its detail but it covers medical services only. On
16 the basis that there are other services, that medical
17 service is not the only component of proper health
18 service and on that basis that the dentistry and these
19 other things would have to be brought within the admini-
20 strative work of Manitoba Medical and thus make use of
21 the administrative set-up that exists without having to
22 set up one, two, three or four more ---

23 DR. TRUEMAN: I would think the Manitoba
24 Medical Service could undertake this additional provision
25 of ancillary health services, ancillary medical services.

26 DR. RABSON: I think, however, we do not
27 feel that the Manitoba Medical Service should be the
28 sole purveyor.

29 THE CHAIRMAN: I am not suggesting that
30 at all, I am staying away from this idea of commercial
carriers. However, on the assumption that Manitoba
Medical should be chosen, I am just wondering if the

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5 the instrument that they have brought into being used as
6 the administrative body for all the services that would
7 go under the designation of health services.

8 DR. TRUEMAN: Yes, I think I could agree
9 to that. As Dr. McIntyre said this morning, the matter
10 of the administration, all the Board of Trustees of the
11 Manitoba Medical Service are interested in a method of
12 supplying those additional or ancillary services. They
13 have demonstrated their ability to do this by establishing
14 a subsidiary company for this purpose which could be
15 incorporated or included, I am sure, in the usual day-by-
16 day activities, functions, of the Manitoba Medical Service.

17 THE CHAIRMAN: It would be a matter of
18 some departmentalization?

19 DR. TRUEMAN: A matter of technique and I
20 am sure they are capable of handling it.

21 DR. RABSON: May I add one thought to that
22 for your consideration? Deterrents have been talked
23 about and now we are considering, in your question, a
24 plan to cover all aspects of health care. It is consi-
25 dered by some people and it is worth considering that
26 medical service insurance should be comprehensive, parti-
27 cularly to the low income groups. These other facets
28 of health care may act as a deterrent. For instance,
29 if you do not cover everything, if you leave drugs
30 partially paid for, if you leave other aspects, physio-
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THE CHAIRMAN: Am I to understand from that that the medical profession really only wants to cover medical services with Government subsidy? That is what you advocated this morning, Government subsidy for medical services only but not for dentistry, not for drugs, not for these other things?

DR. RABSON: I am not disagreeing with Dr. Trueman, I am merely saying in the concept of providing other health benefits some attention could be paid to this aspect, these further aspects acting as a deterrent in health care. I do not think we have decided on the wisdom of adding all these other things.

THE CHAIRMAN: It may not be your wisdom that will decide. This decision will be made at another level, it will have to be made at Government level. All we are asking you is if the decision is made can you undertake to do the work?

DR. COOKE: Perhaps through modesty or wishing to avoid an argumentative topic, you will notice that the Chairman agreed we would be interested in extending the coverage to ancillary services. I think the Manitoba Medical Service would not like it to go on the record that the Manitoba Medical Service would like to undertake paying chiropractors even, as was said here, who are being used by a great many politicians. When the chiropractor goes to a medical school and obtains a medical degree we would then be quite happy to accept him for a role in the Manitoba Medical Service.

THE CHAIRMAN: When the druggist goes does he get a medical certificate?

THE CHAIRMAN: Am I to understand from

that that the medical profession really only wants to cover medical services with Government subsidy? That is what you advocated this morning, Government subsidy for medical services only but not for dentistry, not for drugs, not for these other things?

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4 DR. COOKE: He is trained under the auspices
5 of the University of one of the Universities of Canada
6 and I would sense the feeling of the Manitoba Medical
7 Association that if and when the chiropractic practice
8 is established within the bounds of the University system
9 of our country it would then become a proper topic for
10 this particular study. I do not wish to stir up an
11 argument but I feel that the members of the Manitoba
12 Medical Service who are able to speak at this moment
13 only through this group would not like it to go on the
14 record that we are willing to provide this type of
15 coverage.

16 THE CHAIRMAN: May we accept your views
17 as saying that you would be unwilling to accept?

18 DR. COOKE: As Mr. Roblin said yesterday,
19 this would have to be a matter for study.

20 THE CHAIRMAN: I am asking you now.

21 DR. COOKE: As far as I am concerned I
22 would be willing to accept the chiropractors after they
23 have been accepted in the University system of our
24 country and obtained a scientific training and after that
25 if they insisted on practising chiropracty then I will
26 accept it.

27 THE CHAIRMAN: We won't get into a discus-
28 sion of that. We are now dealing with what is now a
29 reality, chiropractors do not exist in the void, they
30 exist as people giving some measure of health service
according to the views that some hold. As I understand,
the concept of the Manitoba Medical Association thinks
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4 Would you deny to the individual the right to see a
5 chiropractor? Does the Manitoba Medical Association
6 take that position?

7 DR. TRUEMAN: I do not think we need be
8 delayed by this too long. I think as far as the Manitoba
9 Medical Association is concerned it would be quite
10 satisfied to provide all those services which are provided
11 by a doctor or provided under the direction of a doctor
12 among those ancillary services which the Manitoba Medical
13 Service could provide. I think the question of chiro-
14 praxy is perhaps beyond the area of this.

15 THE CHAIRMAN: I am sure dentistry is
16 beyond; is not pharmacy beyond?

17 DR. TRUEMAN: Not at all, no. I think
18 those fields can very properly be included in the
19 service provided by an insurance company whether it is
20 a private insurer or one sponsored by the medical profes-
21 sion.

22 COMMISSIONER BALTZAN: I want to begin
23 with paying my compliments to you, Dr. Trueman and your
24 associates for these reasons: my reading of your brief
25 indicates a very great concern for the people, the
26 patients and would-be patients as much or more than the
27 interest of the Manitoba Medical Association. That is
28 my interpretation, the impression you have left with me.

29 Now, I refer you to page 1 or A1, sub-
30 section A5, restrictions imposed by outside bodies which
interfere with the professional component of medical
care and will adversely affect the quality of medical
care. Now, my question is, have you possibly at your

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4 fingertips, in order that you might save us time, have
5 you at your fingertips those things which you consider
6 outside bodies or those bodies that are outside of your
7 contention?

8 DR. TRUEMAN: We had in mind here, Mr.
9 Chairman, the relation of authoritative bodies of govern-
10 mental nature in their relationship to the practice of
11 medicine. Authoritative bodies of governmental nature
12 capable of imposing by-law strictures or controls,
13 restraints on the practice of medicine as we understand
14 the practice of medicine should be undertaken.

15 COMMISSIONER BALTZAN: Then chiefly it is
16 legislative and legal?

17 DR. TRUEMAN: Yes.
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4 THE CHAIRMAN: Just rather than leave that
5 in a void, is it your position that you don't want the
6 legislature to really concern itself about the practice
7 of medicine?

8 DR. TRUEMAN: Of course not, Mr. Chairman;
9 any effort that government makes in an effort to improve
10 the health of the people of this province will be supported
11 fully by the Manitoba Medical Association. We feel,
12 however, that we as experts in the provision of health
13 services by tradition, by training, by our occupation,
14 are in a position to advise the Government, and would
15 feel it was proper for government to listen to our advice.
16 We don't mean by that that we would be right always, but
17 we feel that we would certainly be able to make a contri-
18 bution in any regulations or legislation which government
19 might feel is indicated in the proper care of people in
20 this province.

21 DR. RABSON: The difference, Mr. Chairman,
22 is between working with government and being under the
23 control of government. I think it is as simple as that.

24 THE CHAIRMAN: Are we not all under
25 control of government?

26 DR. RABSON: Not in the discharge of our
27 technical duties. We are under control as far as our
28 civil rights are concerned.

29 DR. TRUEMAN: Mr. Chairman, I should turn
30 that question back to you, as an eminent jurist and a
legal authority.

COMMISSIONER BALTZAN: Dr. Trueman, page
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3 shall read: "---until Canada is proud to reveal her show-
4 case of medical and other health services as examples of
5 what can be achieved by government and private enterprise",
6 and I assume you imply the voluntary system, "which
7 recognizes the natural and proper spheres which each
8 should occupy". Would you say in respect to that that
9 you support and advocate the voluntary principle as against
10 a compulsory system, (a) because the change takes place
11 also to controls of the medical profession and other
12 professions?

13 DR. TRUEMAN: That would be our very great
14 fear, sir, that the medical profession would come under
15 controls which lead to monopoly and compulsion, with
16 consequent impairment of the medical services.

17 COMMISSIONER BALTZAN: And the (b) part of
18 the question, arising out of that. Would you say then too
19 that it is the purpose and the trend of our society that
20 the people of the professions want to preserve the freedom
21 of action as against any compulsory system, freedom from
22 day-to-day as against changes by our elected governments
23 from five years to five years, or even up to 22 years?

24 DR. TRUEMAN: Why 22 years? Well, Dr.
25 Baltzan sir, we feel, and I am afraid I haven't got the
26 full meaning of your question, and perhaps I should,
27 before I try to answer, ask you to repeat the meaning of
28 your question. If you are suggesting that as a result of
29 government interest and government regulation a system
30 will evolve which will limit the freedom of action of a
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3 which leads to compulsion, and there are certain things
4 perhaps suggested in yesterday's proposition that would
5 lead to compulsion. Not today, not tomorrow, not five
6 years from now, but surely in 22 years, and I feel, sir,
7 that we have just as much responsibility for the people
8 living in this country 22 years from now as we have for
9 their care today.

10 COMMISSIONER BALTZAN: Do you extend that
11 freedom, you want to preserve it also for the people to
12 have the same sort of freedom of action, it is not all
because of professional freedom?

13 DR. TRUEMAN: I think that is what I am
14 trying to say, sir, there is a mutual interest here.

15 DR. RABSON: May I say something about
16 this question of compulsion? I think the important thing
17 about this whole proposition of compulsory health care
18 insurance is the fact that no, there is not anybody in
19 the world that really knows the best way to organize and
20 finance health care, and this fact is proven by the fact
21 that you have about ten different systems in as many
22 different countries. No one knows. Our fear is that ---
23 it may turn out that a compulsory system is the best, but
24 we don't think it should be approached by one fell swoop,
25 because we are confident that any government or any poli-
26 tical party aspiring to office will never have the
27 courage to discard it. We think the problem should be
28 approached slowly and carefully, to see how it works.
29 Just as an example to show you people don't know how
30 things work. In the Manitoba Medical Service brief, if
you look at house calls you will see certain figures, and



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5 the great fear of administrators and doctors as well,
6 that instead of getting dressed and getting their
7 children dressed and going to the doctor's office downtown,
8 the people would call the doctor to their house. To the
9 great surprise of everybody, house calls have dropped by
10 several percent over the years, and this is the point we
11 are trying to make. There is nobody, with all due
12 respect I doubt if this Commission will come up with a
13 very definitive answer which will be permanent in its
14 lasting effects, because nobody knows this proposition,
15 and that is why we feel that the methods evolved to look
16 after people in two aspects of health care should be
17 tried, and experimented with slowly, and when they prove
18 to be satisfactory to both the providers and users of the
19 care, at that time they can be accepted. We feel this is
20 the fundamental question.

21 COMMISSIONER BALTZAN: At this stage you
22 are not prepared to say who is the best qualified. On
23 page A5, paragraph 10, I hope never to interfere or to
24 question about any of your principles. I want perhaps
25 a little explanation, and I read paragraph 10: "That the
26 system of part-time teachers in the medical schools and
27 open hospitals be continued as this produces a high
28 level of medical competence with benefit to the patients,
29 students and doctors". My question, gentlemen, is this:
30 how do you view the statement made yesterday, in yesterday's submission, that the Faculty of Medicine of the University, and I underline again, as I did yesterday, controls teaching in your several teaching hospitals, and



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4 I mention this alongside with other ways of achieving the
5 same objective, the same high ideals with such substitute
6 words as collaboration, co-operation, union of minds
7 and purposes. My question is, how do you view the state-
8 ment that the Faculty of Medicine controls teaching in
9 your several teaching hospitals, as against joining with
you, or you joining with them, in a co-operative ---

10 DR. TRUEMAN: Well, I think Mr. Chairman,
11 that this can be divided up into a number of areas.
12 First of all, there is a curriculum to be determined by
13 medical authorities, and the curriculum and the require-
14 ments, and the curriculum certainly should be under the
15 control, because certain things must be taught in order
16 to produce the full doctor, the complete doctor. On the
17 other hand, I don't think that Dr. Gemmell meant to use
18 the word control as to the specific methods by which the
19 teachers, whether they be part-time or full-time, whether
20 they be professors or practising doctors, would apply the
21 principles which are of necessity to be taught to the
22 medical student or the post-graduate student. I think
23 there the Faculty would suggest, or seek to administer,
24 but the word control, I am sure, is not the operational
25 word when it comes to the doctor's way of teaching his
26 students. As you know sir, as a teacher, every doctor
27 has his own way of teaching, and of getting information
28 across to his students. The important thing is that the
29 student should receive the information. The Faculty,
30 as I said first, has its responsibility to make sure that
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COMMISSIONER BALTZAN: Well, thank you very much, because that really is in line with Dr. Gemmell's later elaboration on the use of the term, or the word. Finally, gentlemen, on page A5, paragraph 3, I hope I don't get into hot water. I don't intend that. We are here to explore, as the Chairman has said lots of times before, and we want to have things as clear as we can, and I read paragraph 3 on page A5, I think that is what I said, No. 3: "That the fee-for-service method of remuneration is superior to other alternate methods of providing personal medical care". That is a principle, and I am not going to say anything more than simply inquire. It can be taken as a sweeping statement. It can be regarded perhaps as a dogmatic or even as foolproof, and it seems to me, and I would like to have that explained, there must be reasons for this firm stand. It must be intended as a bulwark, I asked myself, against more subtle forces, that this speaking of fee-for-service is not, I believe, I want to hear, intended in terms of dollar and cents values and earnings for profit and gain. One can see that gain is not the case as by the voluntary reduction in collection of fees by your Medical Association of Manitoba, so I am trying to get under the surface, if I can get some help. My question is, what other forces does the fee-for-service tend to control, or obviate? May I help you and help me? Is this regarded as useful to promote the conscience and integrity of the medical profession? Is there any reason for it, or is this one of the reasons to the best of the medical profession's experience?

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4 DR. TRUEMAN: Mr. Chairman, there are a
5 number of principles involved here as they affect medical
6 practice. May I refer this question to Dr. Cooke for
7 his consideration?

8 COMMISSIONER BALTZAN: Yes please.

9 DR. COOKE: Mr. Chairman, you are correct
10 that there is more to this statement than meets the eye.
11 You are familiar, I am sure, with other methods of paying
12 doctors as operate in this country and elsewhere. If
13 you base the thought on the welfare of the patient and
14 the adequate reward and stimulus to the doctor rendering
15 the service, if you look at it from those two sides of
16 the question, but we want to have a system which provides
17 the welfare of the patient and rewards the doctor doing
18 the work. There are four common methods of paying the
19 doctor in the western world. Capitation in England,
20 where a sum of money is assessed on each doctor's patient,
21 or panel as it is called. The salary system, as used in
22 this country and elsewhere. A sessional fee, where
23 doctors are paid by the hour if you like for an afternoon's
24 service in a clinic. And fee-for-service, which accounts
25 for the bulk of medical services rendered in our country.
26 If we were to take these one by one: capitation pays for
27 work not done; that is not necessarily bad, but capitation
28 penalizes the industrious practitioner, who by working
29 hard has a higher overhead, uses more gasoline, more
30 cotton batting in his office, and more hours and he takes
home less pay, whereas the chap who may be slothful and
cuts his overhead down may end up taking more pay home.

CHAIRMAN: Do you say that is the



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WILLIAM: Do you say that is the



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3 overall result of the outstanding capitation project of
4 this continent, H.I.P?

5 DR. COOKE: You cannot say the overall
6 result. All you can say is the result of the doctor/
7 patient incident. If he goes to see a patient he
8 renders a service, if he does not go to see a patient he
9 does not render a service. The capitation does not take
10 note of these two incidents. H.I.P. or "Hip" as we call
11 it, pays for night calls. It has found it necessary to
12 do so. Capitation encourages large panels, as has been
13 criticized in the Lancet, the British medical journal,
14 and encourages doctors to take on as large a panel as is
15 legally possible, and we consider that this may diminish
the quality of care that that doctor can supply.

16 THE CHAIRMAN: You are talking of capitation
17 on an individual basis?

18 DR. COOKE: Yes sir.

19 THE CHAIRMAN: What about on a group basis?

20 DR. COOKE: Well, if you have capitation
21 on a group basis, this really equates to the salary
22 method of service, which is used in certain circumstances
23 in our country, and is a very widely accepted method of
24 payment for non-personal services. We have no quarrel
25 with the salary method of paying doctors for administra-
26 tion and public health work. We have long accepted it
27 in this country under particular circumstances. The ses-
28 sional fees are equally applicable to certain circumstances.
29 The D.V.A. and Department of Indian Health and Welfare
30 uses it, and in certain circumstances where a personal
physician's services are not rendered, where they are



overall result of the outstanding capitation project of

this continent, N.I.P.?

DR. COOK: You cannot say the overall

result. All you can say is the result of the doctor's

patient incident. If he goes to see a patient he

renders a service, if he does not go to see a patient he

does not render a service. The capitation does not take

note of these two incidents. N.I.P. or "lip" as we call

it, pays for night calls. It has found it necessary to

do so. Capitation encourages large panels, as has been

criticized in the Lancet, the British Medical Journal,

and encourages doctors to take on as large a panel as is

legally possible, and we consider that this may diminish

the quality of care that that doctor can supply.

THE CHAIRMAN: You are talking of quality of

THE CHAIRMAN: What about on a group basis?

DR. COOK: Well, if you have capitation

on a group basis, this really equates to the salary

method of service, which is used in certain circumstances

in our country, and is a very widely accepted method of

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3 contracted through government for Indians and the D.V.A.,
4 if a man attends for an afternoon clinic, this is satis-
5 factory. The fee-for-service method we support for many
6 reasons. This is a system which pays the doctor for
7 rendering a particular personal service to a particular
8 patient who has called him, and we think this is a more
9 honest and direct relationship of effort and reward.
10 This is a system that rewards the industrious doctor,
11 the young doctor who is willing to get up at night, and
12 it rewards him at the time he does the work. If he is
13 lazy or tired and wishes to pass the work to somebody
14 else, it is passed immediately and not at some future
15 time. This is an excellent system for encouraging young
16 doctors who are working at night, or taking the load off
17 an older doctor's shoulders. They get the reward for the
18 work they do there and then, and are not so likely to be
19 exploited by their colleagues, which even in the medical
20 profession might happen. Fee-for-service compares
21 favourably with the salary method of Britain. There are
22 a large group of young specialists in the British hospitals
23 who are paid salaries at rank of registrar. They do the
24 bulk of the work, and for a large number, compared to a
25 small number in consultant posts which they hope ultimately
26 to gain. A few consultants do most work. Consultants
27 receive much greater rewards. The young registrar is led
28 on by the remote possibility of obtaining an unlikely
29 consultant post obtainable in the distant future. This
30 is a system that you could almost call feudal, and in
fact in the British medical press it has been claimed that
old doctors are really exploiting the young doctors by



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fact in the British medical press it has been claimed that
old doctors are really exploiting the young doctors by



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4 this system. In our country it is not this way today,
5 and we hope it never will be.

6 COMMISSIONER BALTZAN: Thank you for
7 supporting me in the statement that there is there more
8 than meets the eye. In that same connection, is it true
9 that it is more helpful by this practice for the physician
10 to understand the patient's sickness, but also to under-
11 stand his needs and his concerns better?

12 DR. COOKE: Yes sir.
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COMMISSIONER BARTON: Thank you for

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that it is more helpful by this practice for the physician
to understand the patient's sickness, but also to under-
stand his needs and his concerns better?



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4 COMMISSIONER BALTZAN: Nearly lastly, if
5 all objectionable forces were eliminated -- and these
6 are very serious objections, and I am sure you will be
7 able to enumerate for us later some of these objections --
8 if all these objectionable forces were eliminated,
9 wouldn't it help the physicians to be relieved of this
10 bothersome business feature providing all these elements
11 are removed?

12 DR. COOKE: Yes, I think that the brief
13 presented this morning would support your statement that
14 in Manitoba the Manitoba Medical Service has relieved
15 the doctors of some of these unpleasant components of
16 this life.

17 COMMISSIONER BALTZAN: And there may be
18 some possibility to that effect. Lastly I would like to
19 finish on the note I started, and it is to me personally
20 pleasing to see that all health improvements -- and they
21 are substantial in Canada -- are not claimed to be
22 entirely the result of the advances in medical science.
23 You pay homage to technology and engineering, and food
24 and shelter and other necessities which are human contri-
25 butions. All of these contribute to the aims of eradica-
26 ting disease and improving the health of the nation, and
27 with that I thank you.

28 COMMISSIONER McCUTCHEON: Dr. Frueman,
29 your final recommendation is that health insurance
30 premiums be an income tax deductible item; as far as I
can see there is no definite support for that in the
brief. There is no reference in the brief. Is that
merely the normal desire we all have to pay less income



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All objectionable forces were eliminated -- and these are very serious objections, and I am sure you will be able to enumerate for us later some of these objections -- if all these objectionable forces were eliminated, wouldn't it help the physicians to be relieved of this bothersome business feature providing all these elements

DR. COOPER: Yes, I think that the brief presented this morning would support your statement that in Manitoba the Manitoba Medical Service has relieved the doctors of some of these unpleasant components of this life.

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Your final recommendation is that health insurance be provided as an income tax credit. I am sure that there is no definite answer to this in the world. There is no reference in the brief, is that merely the normal desire to all have to pay less income



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3 tax?

4 DR. TRUEMAN: Sir, I would agree with that.
5 Actually No. 12 represents a plan that we had intended
6 to present to you. This was deferred, but the recommenda-
7 tion was left there in order that we would have a taking-
8 off point for the presentation of our supplementary
9 brief. No. 12 has no further support from us for the
10 time being.

11 COMMISSIONER McCUTCHEON: Are you abandoning
12 that? It represents a very big subsidy to a group of
13 people you claim do not need subsidy?

14 DR. TRUEMAN: I do not think that presently
15 I would like to discuss this, inasmuch as we have no
16 background information available to give to you. I must
17 apologize that this recommendation is there, and I give
18 you the reason why it has been left there, and as I
19 promised Professor Firestone, some time after this
20 Commission is over, I would give him the history pertaining
21 to this particular item. I must apologize, Mr. McCutcheon,
22 if I don't wish to pursue this further.

23 COMMISSIONER McCUTCHEON: I don't want to
24 embarrass you, Dr. Trueman, but may I put it this way:
25 was this your first plan and this your second plan?

26 DR. TRUEMAN: The second plan was a modifi-
27 cation of our first plan which would have involved a
28 larger proportion of the people of Manitoba in coverage
29 by a prepaid medical insurer, and we would have made more
30 use of the income tax method of determining who should
pay what proportion of his premium by subscription for the
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service.



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4 DR. RABSON: Mr. Chairman, we would hope
5 that the validity of our argument would appeal to you
6 and the members of the Commission, but it seems ---

7 THE CHAIRMAN: The validity of which
8 argument -- about the income tax?

9 DR. RABSON: The argument that, how can a
10 government say to a person, "You make enough money to pay
11 out of your income to support this government", and then
12 turn around and subsidize that individual for a personal
13 service he receives. We have come to the conclusion this
14 is inconsistent, and that is why we abandoned the income
15 tax deductions. After we had dealt with this problem at
16 some length, it dawned on us.

17 COMMISSIONER McCUTCHEON: So, Doctor, you
18 are saying you are abandoning recommendation No. 12?

19 DR. RABSON: That is right.

20 COMMISSIONER FIRESTONE: Dr. Trueman, I
21 would like to congratulate you and your associates on
22 the tremendous amount of homework you have done. You
23 have produced for the Commission the largest brief we
24 have so far received.

25 DR. TRUEMAN: Mr. Chairman, if we had had
26 longer it would have been shorter.

27 COMMISSIONER FIRESTONE: And in addition,
28 sir, you have gone to a lot of trouble to spell out some
29 of your recommendations in specific terms. You have under-
30 taken surveys to substantiate your proposals, and we find
this most helpful. You also hired an eminent economist
to strengthen your case, and we are very grateful to you
and Professor Barber. I hope you will be patient with me;

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4 I have a number of questions to ask you, but I think, Dr.
5 Trueman, you are somewhat familiar with the sort of
6 principles that the Commission is interested in and
7 interested to learn more about them. What we are really
8 after, as you know, is to understand better what the
9 various medical associations of each province feel are
10 desirable principles in developing a medical care service
11 for Canadians. I take it, first of all, that in repro-
12 ducing the principles of the Canadian Medical Association
13 in pages V and VI of your submission that this means that
14 the Manitoba Medical Association subscribes fully to the
15 principles as laid down by the Canadian Medical Associa-
16 tion?

15 DR. TRUEMAN: That is correct.

16 COMMISSIONER FIRESTONE: Would it be in
17 order, therefore, if I were to ask you and your associates
18 a number of questions concerning your interpretation of
19 these principles as they apply to conditions in Manitoba?

19 DR. TRUEMAN: Of course, yes.

20 COMMISSIONER FIRESTONE: May I therefore
21 begin with the first point which is enumerated on page V:
22 "The Canadian Medical Association believes..." -- and
23 understand, therefore, the Manitoba Medical Association
24 believes -- "...the highest standard of medical services
25 should be available to every resident of Canada", and, in
26 your case, to every resident of Manitoba. I take it that
27 by supporting this particular principle you have in mind
28 a comprehensive program of medical services to be made
29 available to the people of Manitoba in accordance with
30 paragraph 2 of the supplementary brief where you say that

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understand, therefore, the Manitoba Medical Association believes -- "...the highest standard of medical services should be available to every resident of Canada", and, in your case, to every resident of Manitoba. I take it that by supporting this particular principle you have in mind a comprehensive program of medical services to be made available to the people of Manitoba in accordance with paragraph 2 of the supplementary brief where you say that



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4 you advocate a universally available medical service
5 comprehensive in scope?

6 DR. TRUEMAN: Yes, but I must qualify that,
7 of course, Mr. Chairman. This is what we would like to
8 be available to every resident of Manitoba, but these
9 comprehensive services can only be available where they
10 exist, and they must be brought to the patient or the
11 patient brought to the service, and it is quite apparent
12 that there must be isolated portions of our province
13 where these services cannot be brought to the patient.
14 This, I think, is a most reasonable qualification.

15 COMMISSIONER FIRESTONE: I take it from
16 what you say that where comprehensive medical services
17 do not exist because certain facilities are lacking, that
18 your Association would be in favour of creating such
19 facilities providing this can be done in a practical and
20 reasonable manner?

21 DR. TRUEMAN: Yes.

22 COMMISSIONER FIRESTONE: May I now turn to
23 the second principle which reads: "Insurance to prepay
24 the costs of medical services should be available to all,
25 regardless of age, state of health or financial status".
26 I take it in endorsing this principle you have in mind
27 a universally available scheme to all the people of Mani-
28 toba in accordance with paragraph 2 of your supplementary
29 submission?

30 DR. TRUEMAN: That is so, sir.

COMMISSIONER FIRESTONE: Principle 3:
"Certain individuals require assistance to pay medical
services insurance costs". Do I take it from this that

you advocate a universally available medical service comprehensive in scope?

of course, Mr. Chairman. This is what we would like to be available to every resident of Manitoba, but these comprehensive services can only be available where they exist, and they must be brought to the patient or the patient brought to the service, and it is quite apparent that there must be isolated portions of our province where these services cannot be brought to the patient. This, I think, is a most reasonable qualification.

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DR. TROTMAN: Yes.

COMMISSIONER FIRESTONE: May I now turn to

the second principle which reads: "Insurance to provide the costs of medical services should be available to all, regardless of age, state of health or financial status". I take it in endorsing this principle you have in mind a universally available scheme to all the people of Manitoba in accordance with paragraph 2 of your supplementary

DR. TROTMAN: That is so, sir.

"Certain individuals require assistance to pay medical services insurance costs". Do I take it from this that



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4 you support a concept of the community sharing responsi-
5 bility for paying either part or all of the cost of
6 medical services for people who are not in a position to
7 pay for these costs themselves?

8 DR. TRUEMAN: That is so, sir.

9 COMMISSIONER FIRESTONE: And that you are,
10 for these particular groups, in favour of the subsidy
11 arrangements?

12 DR. TRUEMAN: That is so, sir.

13 COMMISSIONER FIRESTONE: And you have no
14 objection to these subsidies being paid by governments?

15 DR. TRUEMAN: No, none at all.

16 COMMISSIONER FIRESTONE: We now come to
17 principle 4: "The efforts of organized medicine, govern-
18 ments and all other interested bodies should be co-ordi-
19 nated towards these ends". You, therefore, support a
20 co-operative scheme in which physicians, insurance
21 carriers and governments would work together?

22 DR. TRUEMAN: Yes, we would agree with
23 that.

24 COMMISSIONER FIRESTONE: You say, "While
25 there are certain aspects of medical services in which
26 tax-supported programs are necessary, a tax-supported
27 comprehensive program compulsory for all, is neither
28 necessary nor desirable". Could you explain to us what
29 are the objections of the Manitoba Medical Association
30 to a scheme which is tax-supported, comprehensive and
compulsory for all?

DR. TRUEMAN: Mr. Chairman, before I
attempt to discuss this I would like to qualify the

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4 sentence to some degree. For instance, there are certain
5 tax-supported programs which of necessity involve compul-
6 sion. Let us use, for example, the care of those ill
7 with tuberculosis: their illness requires that they be
8 isolated in a special hospital, and here we feel that a
9 tax-supported program is most essential, and perhaps the
10 same applies to the care of mental diseases although the
11 concept here of payment on a fee-for-service for the care
12 of mental diseases is appearing.

13 The latter part of the sentence -- "...a
14 tax-supported comprehensive program compulsory for all..."
15 is felt by the Canadian Medical Association and the
16 Manitoba Medical Association as neither necessary nor
17 desirable for a number of reasons, and if I may take a
18 minute, Mr. Chairman, I think many of us here might like
19 to discuss this matter.

20 First of all, we feel that the duty of
21 the doctor is primarily to his patient, and we have
22 learned from experience that a compulsory service takes
23 the responsibility away from the doctor to a degree and
24 becomes a matter of the administration of the program.
25 The administration undertakes to control too much in
26 such a scheme. We feel that professional self-discipline
27 operates in current voluntary plans and that this would
28 be a difficult matter perhaps to control under a govern-
29 ment scheme. Perhaps a matter of less consequence is
30 that luxury medical services are demanded by some people
in our society who can afford them, and that these could
not be insured by a compulsory plan, and these people
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3 please. If they are involved in the compulsory service,
4 then in order to obtain the services they wish in addition
5 to those provided by the compulsory service, they have
6 to pay two times. Again, multiple carriers by their
7 competition are preferable to a one monopolistic single
8 government plan. Competition of other government respon-
9 sibilities will inevitably limit the funds available
10 under any compulsory plan, and the financial freeze will
11 limit the development financially and medical-benefit-
12 wise of the medical insurance plan. To make such a plan
13 work you must involve acceptance of the proration program
14 which works very well in a doctor-sponsored scheme invol-
15 ving the loyalty and interest of doctors in their own
16 fate, but it is unlikely to be so acceptable under a
17 compulsory scheme. Failure -- and I repeat Dr. Rabson's
18 words of a few minutes ago -- failure to provide the
19 greatest benefit to the area of the greatest need and
20 provide benefit to those who need it least is the result
21 of a compulsory scheme. On the basis of the English
22 experience, restrictions and controls abound, and these
23 influence adversely the principles of practice and thus
24 adversely affect the medical services available to the
25 people involved in the scheme.

26 This may be a little more difficult to
27 prove, but we feel the strictures involved in the compul-
28 sory scheme may limit the recruitment of doctors and in
29 fact may drive doctors away from their practices.

30 I think, Mr. Chairman, that these are
some of the reasons why doctors regard the possibility of
a compulsory scheme with a great deal of concern, not just

32 some of the reasons why doctors regard the possibility of a compulsory scheme with a great deal of concern, not just I think, Mr. Chairman, that these are fact may drive doctors away from their practices, every scheme may limit the recruitment of doctors and in prove, but we feel the structures involved in the compulsory scheme may be a little more difficult to people involved in the scheme. adversely affect the medical services available to the influence adversely the principles of practice and thus experience, restrictions and controls abound, and these of a compulsory scheme. On the basis of the English provide benefit to those who need it least is the result greatest benefit to the area of the greatest need and words of a few minutes ago -- failure to provide the compulsory scheme. Failure -- and I repeat Dr. Radson's late, but it is unlikely to be so acceptable under a ving the loyalty and interest of doctors in their own which works very well in a doctor-sponsored scheme invol- work you must involve acceptance of the provision program wise of the medical insurance plan. To make such a plan limit the development financially and medical-benefit- under any compulsory plan, and the financial freeze will abilities will inevitably limit the funds available government plan. Competition of other government respon- competition are preferable to a one monopolistic single to pay two times. Again, multiple carriers by their to those provided by the compulsory service, they have then in order to obtain the services they wish in addition please. If they are involved in the compulsory service,



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3 because of their own fate but because of the impact that
4 restraints and controls will have upon the general provi-
5 sion of medical services to the people.

6 I would like Dr. Rabson to speak to this,
7 sir, please..

8 COMMISSIONER BALTZAN: Where can I find
9 that summary you have just mentioned?

10 DR. TRUEMAN: On the back of this envelope.

11 DR. RABSON: That is where Abe Lincoln
12 used to write his speeches. I think the point Dr. Trueman
13 just made is one of the most telling in this debate about
14 compulsion or no compulsion. Regardless of what type of
15 plan is involved in the final analysis the medical care
16 that any patient gets is going to depend upon the profes-
17 sional skill and the character of the man giving it.

18 Now, to attract the higher type of man to this profession
19 you have to have the most attractive set of circumstances
20 for them to work with and in our opinion government
21 compulsion by control is the least attractive. I think
22 that after yesterday there would be no more questions
23 about compulsion. May I refer, with your permission, to
24 the brief presented by the Minister of Health yesterday.
25 Through this brief health grants were mentioned and I
26 call your attention to page 33, paragraph b at paragraph
27 169:

28 "A comprehensive vocational rehabilitation
29 program cannot be developed through the
30 use of health grants with their limitations
and 'ceilings'".

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4 recommendations about health grants he thought that the
5 health grants should be reviewed very frequently because
6 of their inflexibility. This is, I think, a characteristic
7 of all completely government-controlled services which
8 are given to people. I would like to say something else
9 about that and I trust in saying this I am not thought
10 to be criticizing government, I am just interested in
11 facts. In 1961 the Manitoba Medical Service filed in
12 the Provincial Legislature through the Government the
13 financial estimates for the year 1961, 1962 and 1963 and
14 the estimated increase in expenditures for each of those
15 years was 13%, 12% and 13%. My figures may not be
16 accurate but they are in that neighbourhood. Yet, in
17 this year the medical service plan has told the hospitals
18 of Manitoba that they cannot increase their budgets more
19 than 3%. Now, if anything is going to lead to advances
20 in the quality of care rendered in the hospitals it is
21 going to be a decrease in their budgetary estimates. I
22 think that is so latent an example of what happens when
23 government has a complete monopoly over a service. I am
24 not saying the reasons for doing this are wrong, but I
25 think they should convince anybody that any monopoly,
26 whether it is government or anybody else in any field,
27 leads to this sort of control which, as we submit to you,
28 is detrimental to quality.

29 I would like to read you something written
30 by the Vice-President of the Rockefeller Foundation,
31 Alan Grey, in a book called "Challenges to Temporary
32 Medicine". He has no axe to grind and he says here:

"I believe voluntary prepayment preferable

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4 to any other method because it avoids
5 centralized bureaucratic control, assures
6 valid comparison and adaptability of plans
7 and physicians experiment and initiate and
8 particularly because voluntary insurance
9 stimulates the vigilance that is the
10 price of freedom and so educates the
11 consumers of medical care".

12 I think it must be obvious that when
13 medical care is paid for by premiums and those premiums
14 increase that the people paying those premiums get
15 vitally interested but when the vast majority of costs
16 are paid out of revenues very few people know it has
17 happened because they only know their taxes are going up.
18 I think this is also objectionable.

19 I would like to go back to the statement
20 I made before that the experience in all government-
21 controlled plans, and this is outside of school boards,
22 has been that a budget is set and plans made to fit the
23 budget and in health care we do not think that should
24 happen. We think the plan should be such that whatever
25 is needed should be put forward and paid for and the
26 budget in some way raised. That is why we think the
27 people who can afford to pay for it should pay for it
28 and I think it is our fundamental concept. The statement
29 I used in answer to Dr. Baltzan's statements must also
30 be considered that if we were certain in our minds that
this was the best method of doing it we would advocate
it but it has not been demonstrated and it is only by a
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4 health services can we really find out the best way to
5 do it and I think that is our responsibility.

6 COMMISSIONER FIRESTONE: I would like
7 first of all to refer to a remark that Dr. Rabson made
8 when he said that in view of the discussion we had
9 yesterday on the subject of compulsory, when we listened
10 to a presentation made by the Government of Manitoba,
11 there would perhaps be no need to discuss it today. Do
12 I take it from that that the Manitoba Medical Association
13 feels that the Government of Manitoba is speaking for
14 them?

15 DR. RABSON: I will withdraw that statement.

16 COMMISSIONER FIRESTONE: Thank you very
17 much. May I go back, Doctor Trueman, to the remark you
18 made when you said that in a compulsory system some
19 people may want extra service that would not be covered
20 by such a compulsory system and therefore they would be
21 paying twice for it. Would that be the case if a
22 compulsory or comprehensive universal scheme would be
23 limited to a minimum standard of medical care services
24 and anyone wanting additional services would have to pay
25 for them in the regular manner? Would your statement
26 still hold under such a situation?

27 DR. TRUEMAN: No, it would not.

28 COMMISSIONER FIRESTONE: May I pursue
29 this question, now that I have Dr. Rabson's permission on
30 compulsory, a little further? Under the Hospital Insurance
and Diagnostic Act we have an operation in Canada and
here in Manitoba ---

THE CHAIRMAN: Mr. Pickering, you wish to



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4 make an observation in connection with the statement made
5 by Dr. Rabson?

6 MR. G.L. PICKERING (Commissioner of
7 Manitoba Hospital Services Plan): I do not think we can
8 allow the statement that Dr. Rabson made to go unchallenged.
9 The percentages that were used in our studies were the
10 total cost of providing not only the same service, the
11 additional cost of the same services but also of all the
12 additional services. I have forgotten the percentages
13 we used but if it was 8% there was a very large per-
14 centage of that to cover new hospital beds, new services, a
15 combination plan and 101 other things. In 1961 the
16 increased cost over 1960 over the same volume of services
17 was 3.5% and in 1962 over 1961 we feel that cost can be
18 held at 3%. The statement that this is a complete reversal
19 of government policy is completely wrong and it is
20 misleading because it fails to take into account the
21 many additional services that will be provided and that
22 is what accounts for the percentage over and above 3%.

23 DR. RABSON: May I reply to that from this
24 book which I would be prepared to file?

25 THE CHAIRMAN: You may file the book but
26 we are not going to have any debate.

27 DR. RABSON: May I just answer that state-
28 ment because according to my - I do not wish to be wrong
29 in this but the provision for increase in patient-day
30 volume cost of additional beds was 4 ---

THE CHAIRMAN: Dr. Rabson, did you hear
what I said?

DR. RABSON: No, sir.

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DR. RABSON: Yes, sir.



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4 THE CHAIRMAN: I said I was not going to
5 permit a debate. You may file the document.

6
7 THE SECRETARY: That will be Exhibit 55C.

8 --- EXHIBIT NO. 55C: Report on financial estimates of
9 the Manitoba Hospital Services
10 Plan.

11 COMMISSIONER FIRESTONE: With your permis-
12 sion, if I might continue. Dr. Trueman, you have in
13 operation in Manitoba a universal hospital scheme; has
14 that scheme worked out well?

15 DR. TRUEMAN: I think it has worked out
16 very well.

17 COMMISSIONER FIRESTONE: Are the people of
18 Manitoba satisfied with the sort of service that they
19 get under that scheme? I would not suggest there is any
20 scheme that you could not improve upon, I was very much
21 impressed with Dr. Rabson's words of advice that one
22 should approach any program gradually, slowly, and
23 improve upon it. In the light of experience I think that
24 is a sensible and practical way of going about it. But,
25 allowing for this sort of improvement we all know can be
26 made, by and large, this scheme has been considered
27 satisfactory from the point of view of the people of
28 Manitoba as well as the practising physicians in Manitoba?

29 DR. TRUEMAN: I would say so.

30 COMMISSIONER FIRESTONE: Now, this scheme
covers everybody in Manitoba?

DR. TRUEMAN: Dr. Johnson yesterday said
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4 COMMISSIONER FIRESTONE: Almost everybody
in Manitoba. Now, how is that scheme paid for?

5 DR. TRUEMAN: It is paid for in a number
6 of ways, Mr. Chairman. There is a premium which is paid
7 at regular intervals by the subscriber. There is a -
8 the word is not subsidy - there is an agreed amount
9 depending on the population of the province paid by the
10 Federal Government into the Treasury of the Provincial
11 Government and then the Provincial Government contributes
12 approximately \$3,000,000 a year to meet the hospital
13 premiums of the indigent group, namely the social welfare
14 recipients and those old-age pensioners and old-age
15 assistance groups. In those two groups there are approxi-
16 mately 42,000 or 43,000 people. As far as the Indians
17 are concerned in the province the cost of the premiums
18 are paid by the Federal Government and I think that is
largely the way the program is financed.

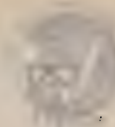
19 COMMISSIONER FIRESTONE: In other words,
20 you are saying that this program is financed partly out
21 of premium income, partly out of the general revenue
22 which, in turn, is collected through various taxation
23 measures, corporation taxes, income tax, sales tax, etc.;
is that right?

24 DR. TRUEMAN: What were the last two?

25 COMMISSIONER FIRESTONE: All kinds of
26 taxes, income tax, corporation tax, and sales tax.

27 DR. TRUEMAN: No sales tax in Manitoba,
sir.

28 COMMISSIONER FIRESTONE: I am referring to
29 the payments made out of general revenue which are
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4 coming from various taxation sources of which sales tax
5 is one, it is not designated but the general revenue is
6 made up of various taxes.

7 DR. TRUEMAN: Yes.

8 COMMISSIONER FIRESTONE: Would you there-
9 fore say that in the hospital field we have in existence
10 a tax-supported comprehensive program compulsory for all?

11 DR. TRUEMAN: Yes.

12 COMMISSIONER FIRESTONE: Dr. Trueman, why
13 do you feel that in the hospitalization field it would
14 be quite all right to have a tax-supported comprehensive
15 program compulsory for all but not in the field of medi-
16 cal services?

17 DR. TRUEMAN: Mr. Chairman, I think there
18 are a number of reasons and some of these are quite
19 obvious. There is more than a subtle difference between
20 the provision of hospital services and the provision of
21 medical services. With some respect I would say the
22 hospital services can be impersonal inasmuch as they
23 supply a room and board and heat and in addition to that,
24 of course, they provide some para-medical services;
25 these services are not so very different from those provided
26 by a private hotel. On the other hand, there is something
27 more personal, more intimate, in the relationship between
28 a doctor and a patient who is ill and this is essentially
29 the difference between medical services provided by a
30 doctor and hospital services provided by some other
organization. Then, in discussing this I must refer you
to some of the reasons I gave you - I refer you to the
reasons which I gave you concerning doctors' inability to

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COMMISSIONER FIRESTONE: Would you therefore say that in the hospital field we have in existence a tax-supported comprehensive program compulsory for all?

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4 accept an element of compulsion in a medical health
5 scheme. Now, there may be others from the Association
6 who would like to add to that.

7 DR. COOKE: Mr. Chairman, regarding the
8 compulsive element, we feel that according to the terms
9 of the Commission to study the health needs of Canada
10 we wish to define needs and we have attempted to do so
11 in regard to the one special heading of physicians'
12 services which, after all, is perhaps far down the list
13 after slum clearance and beds for the chronic ill. Physi-
14 cians' services is a way down the list and we seem to be
15 paying a lot of attention to it. In the field of physi-
16 cians' services we have attempted to define the need and
17 to encourage you to recommend that public funds be spent
18 in this area of need. We feel if a compulsory system
19 was imposed on the citizens of Canada it would be spending
20 public funds in areas other than the areas of need. We
21 feel this would be one more diminution in the freedom of
22 a self-responsible citizen who, if he is going to be
23 responsible for himself, must accept some decision
24 making and some spending of his own money to look after
25 himself. It is our view that to direct public funds in
26 support of a universal compulsive program would be
27 contrary to our whole system. We feed the hungry, not
28 the well; we house and clothe the hungry and not the well.
29 You could pursue this philosophic discussion to a further
30 degree. Beyond this we might say regarding hospitalization
that hospitalization was imposed on us from above without
a referendum and to our knowledge Manitoba Medical Associa-
tion has never gone on record as supporting compulsion.

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9 history. Because we have a compulsory hospitalization
10 system now we believe there is no reason to force further
11 rules upon the citizens and take decisions out of their
12 hands.

13 DR. RABSON: I think also the element of
14 compulsion in hospitalization is easier to enforce than
15 it is in medical care. How much compulsion can you
16 really bring to bear on medical care? The only thing you
17 compel people to do is pay their premium or contribute
18 to a scheme, you cannot compel them to go to a hospital
19 or observe the ordinary health rules which they should
20 observe. It is different because usually when they have
21 to go to a hospital there is no doubt about it and there
22 is very little difficulty in persuading them to go. I
23 think it is a practical matter as well as philosophic.

24 COMMISSIONER FIRESTONE: The Premier of
25 the Province made some comments on this compulsory
26 feature yesterday and he made the distinction between
27 compulsion and voluntary as far as the recipient of
28 medical care is concerned and the providers of medical
29 care. We are mainly concerned with providers of medical
30 care, the physicians. We heard this morning from the
Manitoba Medical Service that almost, if not all the
doctors, the practising physicians in Winnipeg, are
participating members under this scheme; is that correct?



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4 DR. TRUEMAN: All the practising doctors
5 are participating members of the scheme as far as I know,
6 Mr. Chairman.

7 COMMISSIONER FIRESTONE: We were told
8 except perhaps one or two. For practical purposes it is
9 all-inclusive?

10 DR. TRUEMAN: Practically, yes.

11 COMMISSIONER FIRESTONE: I take it they
12 do it on a voluntary basis, there is no compulsion?

13 DR. TRUEMAN: There is no compulsion.

14 COMMISSIONER FIRESTONE: They are being
15 paid monies collected largely through premiums. Some of
16 it comes from the Government of Manitoba. There is no
17 objection by the participating physicians to take some
18 of the funds which are channelled to them for services
19 rendered by the Manitoba Government through the Manitoba
20 Medical Service, is that correct?

21 DR. TRUEMAN: There is no objection sir.

22 COMMISSIONER FIRESTONE: Let us assume for
23 a moment, sir, that instead of the Manitoba Medical
24 Service collecting premiums, the funds are collected
25 through premiums or taxes through government, and the
26 Government passes on the amount of money to cover the
27 cost of the scheme to the Manitoba Medical Service,
28 which is administering the scheme. Would the participating
29 physicians feel any objections to such an arrangement?

30 DR. TRUEMAN: I believe they would not be in
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COMMISSIONER FIRESTONE: Would you feel
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3 Service, which in turn instead of getting part of its
4 money from the Government would get all of its money
5 from the Government, that there is any compulsion
6 involved?

7 DR. TRUEMAN: Yes.

8 COMMISSIONER FIRESTONE: On the part of
9 the doctors, I am referring to.

10 DR. TRUEMAN: I feel a scheme like that
11 involves two elements. One is monopoly of course, and in
12 no time monopoly of medical services would be in the hands
13 of the person who is paying the premiums into the scheme.
14 I think as this happens, sir, and it might not happen
15 today, but as I said earlier it might happen in the near
16 future with a change of government, a change of a sym-
17 pathetic Minister of Health, that controls would be intro-
18 duced into the administration of that scheme, which
19 would affect medical services, and also affect doctors'
20 interest in the services. Presently doctors are loyal to
21 the Manitoba Medical Service, because it is their scheme.
22 It was introduced for one purpose, and that early philo-
23 sophy was to provide a medical service for low income
24 and the medium income people of this province, to cost a
25 moderate subscription or premium, and in order to make
26 this scheme successful and provide those services, the
27 doctors undertook to take a reduction in their fees, and
28 I am sure that should there be controls and restrictions
29 resulting from the competition for funds between the
30 various services of government, and a freezing of the
level of funds available for doctors' services, or a
reduction in those funds, that the doctors would rebel at



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doctors undertook to take a reduction in their fees, and

I am sure that should there be controls and restrictions

resulting from the competition for funds between the

various services of government, and a freezing of the

level of funds available for doctors' services, or a



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4 a reduced prorating at the hands of government, and I am
5 sure, sir, that if this happens, that if this idea were
6 pursued, that this would eventually happen, and I think
it would be a catastrophe.

7 COMMISSIONER McCUTCHEON: Are you saying,
8 Dr. Trueman, in effect, that the medical profession will
9 accept a prorating which it imposes on itself, but it
10 does not want the Government to impose it on them?

11 DR. TRUEMAN: That is exactly what I am
12 saying sir.

13 COMMISSIONER FIRESTONE: I would like to
14 quote to you a statement contained in Premier Roblin's
15 submission which he read yesterday, on page 6: "Through
16 the utilization of national taxing powers an approach
17 has been made to a basic minimum standard of health care
18 for all Canadians while retaining provincial responsibility
19 and administration". I asked the Premier whether this
20 meant the Government of the Province of Manitoba is in
21 favour of a national health care plan through the utiliza-
22 tion of national taxation powers to provide a basic minimum
23 standard of health care for all Canadians, while retaining
24 provincial responsibility and administration, and I under-
stand his answer to be in the affirmative. Now, what I
would like to ask you, sir, does the Medical Association ---

25 THE CHAIRMAN: I would think, Mr. Firestone,
26 that that is perhaps too broad an interpretation of what
27 Premier Roblin said. I understood him to say that he
28 would accept the proposition that any program would have
29 to be a provincial one, and not a national one, the
30 national contribution is money.

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4 COMMISSIONER FIRESTONE: Well, this is what
5 the phrase says in the submission of the Premier, through
6 the utilization of national taxation powers.

7 THE CHAIRMAN: He was speaking of projects
8 which were invoked now through various health grants. He
9 was not speaking of the future in that sentence, Mr.
10 Firestone.

11 COMMISSIONER FIRESTONE: May I return,
12 Dr. Trueman, to the question. Would your Association be
13 in favour of the provision of a basic minimum standard of
14 health care for the people in Manitoba with due respect
15 to provincial responsibility and administration, through
16 the utilization of national taxing powers?

17 DR. TRUEMAN: To a degree, Mr. Chairman,
18 I think in as far as we recognize an area of need, part
19 of which is absolute, and part of which is relevant, we
20 would feel that the application of the taxing powers
21 could be applied to those areas, but beyond that, to
22 those who are able to take care of themselves, and who
23 have demonstrated the ability in increasing numbers over
24 recent years, we would feel that this is neither necessary
25 nor desirable.

26 COMMISSIONER FIRESTONE: May I now proceed
27 to principle 1 on page 5, in the second part of your
28 submission. You refer in this principle 1 that all
29 persons rendering services are legally qualified physi-
30 cians and surgeons. Would this principle include also
para-medical personnel working under the supervision of
a doctor, say a nurse taking x-rays?

DR. TRUEMAN: May I say, would you qualify

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DR. TRUEMAN: May I say, would you qualify



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3 that to say a nurse doing her duties. If you mean
4 nursing services, yes.

5 COMMISSIONER FIRESTONE: I take it from
6 what you are saying, Dr. Trueman, that paragraph 1 can
7 be interpreted therefore broadly to include also para-
8 medical personnel working under the supervision of a
9 doctor?

10 DR. TRUEMAN: Yes.

11 COMMISSIONER FIRESTONE: Thank you. Can
12 I now turn to principle 2, that every resident of Canada
13 is free to select his doctor, and that each doctor is
14 free to choose his patients. Does the Manitoba Medical
15 Association support the right of a doctor to refuse to
16 see a patient?

17 DR. TRUEMAN: We feel, sir, that there
18 are certain situations where a doctor may feel that it
19 is in the interest of the patient to refuse the patient
20 his services, and may I explain this. I have no reference
21 to a situation which may be regarded as an emergency. In
22 such a situation I am sure it would be incomprehensible
23 for a doctor to refuse a patient his services. On the
24 other hand, in the brief are a number of examples of this
25 principle. For instance, if I may use one that I think
26 I remember. A psychiatrist perhaps would refuse to
27 treat a patient with heart disease in the presence of
28 somebody who was better qualified to treat that patient,
29 nor would he treat a pregnant woman if an obstetrician
30 were nearby, and it is this sort of thing that I believe
is involved in this particular principle. On the other
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3 to seek help elsewhere if the patient refuses to follow
4 the doctor's orders.

5 COMMISSIONER FIRESTONE: Yes, that is a
6 very helpful explanation, thank you. Three, that the
7 competence and ability of any doctor is determined only
8 by professional self-government. What are the views of
9 the Manitoba Medical Association on the subject of admis-
10 sion of graduates of foreign universities?

11 DR. TRUEMAN: Mr. Chairman, may I refer this to Dr.
12 Macfarland, the Executive Director of the College of
13 Physicians and Surgeons.

14 DR. MACFARLAND: May I have the question
15 again, Mr. Chairman please?

16 COMMISSIONER FIRESTONE: What are the views
17 of the Manitoba Medical Association on the question of
18 the admission of graduates of foreign universities?

19 DR. MACFARLAND: Mr. Chairman, I think
20 this rightly comes under the purview of the College of
21 Physicians and Surgeons, which is the licensing body in
22 the province.

23 COMMISSIONER FIRESTONE: Well, I appreciate
24 that, but I would like some certain views from the
25 Medical Association. If you feel that you are not in a
26 position to answer this question, I may then go to the
27 next point, and ask you, and this is related to this
28 question, that if you find that you have been unable to
29 attract a sufficiently large number of physicians to
30 practise medicine in Manitoba, and assuming further that
a plan is evolved to extend medical care services in the
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DR. THREMAN: Mr. Chairman, may I refer this to Dr. MacFarland, the Executive Director of the College of Physicians and Surgeons.

DR. MACFARLAND: Now I have the question COMMISSIONER FISHBONE: What are the views of the Manitoba Medical Association on the question of the admission of graduates of foreign universities? this rightly comes under the purview of the College of Physicians and Surgeons, which is the licensing body in the province.

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3 yesterday, that it may take ten years for your own
4 University to train new men and get them into practice,
5 how would you increase that supply significantly enough
6 to take care of the expanded program over the ten-year
7 period? I am talking of the interim period.

8 DR. TRUEMAN: Is this question to Dr.
9 Macfarland or to me?

10 COMMISSIONER FIRESTONE: I am addressing
11 it to you, sir, and allowing you to assign it to any of
12 your colleagues you wish.

13 DR. TRUEMAN: There is no easy way, or
14 quick way to increase the number of doctors practising
15 medicine in Canada, or in Manitoba. We know that in
16 Manitoba we can produce, through our facilities at the
17 University, more doctors without an increase in plant
18 or without much additional expense. As you say, this
19 would take some time. It would not be possible I am sure
20 to bring qualified doctors from any other country for a
21 number of reasons, which too are obvious. Nor would it
22 be proper for us to seek to draw away from any country
23 doctors, or other professional people, who would be
24 required by the people of those countries, within a
25 reasonable number. I must admit that if more services
26 are to be provided, or more people are to live in Manitoba,
27 that there will be some impediment of the quality of
28 medical services. Now, perhaps this can be adjusted by
29 a number of ways. It may be that doctors can work harder
30 and provide more services. It may be that by some organiza-
tion, which we don't have presently, doctors could be
located in centres, and people would be encouraged to

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3 attend those centres, and these centres would then
4 provide, under one building, or under one roof, all the
5 services that would be necessary to take care of a large
6 number of people, because there would be economies
7 effected in doctors' time and doctors' facilities, and
8 beyond that, sir, I haven't the answer to your question.
9 Others in the group may be able to give you some opinion.
10 I know that this is an important question to answer, and
11 possibly there is a better answer than I have given you.

12 COMMISSIONER BALTZAN: In other words,
13 Doctor, you speak of a certain kind of flexibility that
14 has been the experience of the profession. Conversely
15 when, and during the war when so many had gone away to
16 look after the armed forces, and so many less remained
17 in Canada to look after the civilian population, do you
18 think there is any charge that during that time, during
19 that five or six-year period, that there was negligence,
20 or that the people had suffered so largely?

21 DR. TRUEMAN: That is difficult to answer,
22 Mr. Chairman. I am sure that some areas must have
23 suffered the loss of their doctor to the armed forces,
24 and there may have been, not negligence, but neglect
25 because of the absence of a doctor in certain areas
26 formerly served by a doctor. As far as I know, the
27 health of the people of Manitoba didn't suffer much hard-
28 ship during the war years, but this is an imponderable.
29 I really cannot answer it. I just remember that the
30 doctors that remained worked harder and hospitals were
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4 COMMISSIONER BALTZAN: So that the same
5 thing could apply in this projected period of ten years,
6 when the supply may be inadequate, the same principle
7 might apply?

8 DR. TRUEMAN: Yes. There would have to
9 be some economies made of doctors' time, and doctors'
10 services, and there would have to be perhaps some reduc-
11 tion in the quality, but I would not expect that the
12 quality would be reduced so much that hardships would be
13 effected on the people. Perhaps some of the trimmings
14 would be eliminated.

15 DR. RABSON: Mr. Chairman, we have never
16 taken steps to exclude foreign doctors. We are one of
17 the provinces that have reciprocity with the General
18 Labour Council of Great Britain. I think Dr. Cooke has
19 some figures for you.

20 DR. COOKE: On page 121 of the brief there
21 is some factual information. It is interesting to note
22 that in September of 1960 there were 1,033 fully
23 registered physicians in Manitoba. 66% graduated in
24 Manitoba, 10% graduated from elsewhere in Canada. 249
25 doctors, or 24% of the total were foreign graduates. So
26 you will see that we have been fortunate in obtaining
27 the services of many foreign graduates. There are some
28 reasons to believe that the flow of immigration may be
29 diminishing with the rise of the standard of living in
30 Europe and the numbers of graduates from British medical
schools, but as of today we have a large number of foreign
graduates in this province. As Dr. Rabson said, we have
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4 I believe there are only five provinces in Canada which
5 have this. If my information is correct, the larger
6 provinces, Ontario and Quebec, don't have this reciprocity.

7 DR. TRUEMAN: Mr. Chairman, I regret I
8 didn't interpret this question and give you that informa-
9 tion. I didn't think it was involved, but certainly in
10 any scheme providing medical services to the people the
11 matter of manpower and the supply of manpower is of the
12 utmost importance. If we were unable to attract medical
13 students, and if for some reason there was a reduction in
14 the supply of qualified doctors entering the province and
15 settling in the province from foreign areas, we would be
16 in a desperate situation, and just what the cause of a
17 reduction in the interest of young people to enter medi-
18 cine is, one cannot be sure. There are so many reasons.

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4 However, let me advise you that the problem is nothing
5 compared to what it is in England where 75% of medical
6 students are subsidized in an effort to bring medical
7 students into the colleges in order to obtain their educa-
8 tion.

9 If I may quote from the British Medical
10 Journal of December 9th 1961 as follows:

11 "Last week Lord Taylor, opening a debate
12 in the House of Lords on the growing
13 shortage of doctors, described, in a
14 place not encouraging exaggeration, the
15 present position as 'a pretty ghastly,
16 awful picture', and as 'a new and desperate
17 situation'".

18 It goes on to say that the National Health
19 Service hospitals to a great extent depend for the
20 continuation of their work upon some 4,000 foreign
21 doctors, and at the same time they are observing with
22 deep regret British-born doctors with British qualifica-
23 tions leaving their homeland for other countries.

24 So, Mr. Chairman, this is an important
25 matter and I am not saying -- I am not even inferring
26 that the entry of government into the field of medical
27 care and an approach towards a compulsory service would
28 make any difference here, but the English appear to be
29 learning a lesson, and it is a lesson which should not
30 be lost upon those people in Canada who feel there should
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3 Beveridge, from the same article:

4 "Lord Beveridge, we believe, went to the
5 root of the matter when he told his fellow
6 peers of the conclusion of a recent
7 conference of experts 'that there should
8 be an inquiry, not simply as to how much
9 doctors and surgeons and dentists should
10 be paid and from what sources, but into
11 how the health service of the state
12 should be organized in practice and how
13 it should be related to voluntary provi-
14 sion for health made by the citizens them-
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16 being made about opting out of the Health
17 Service, Lord Beveridge said he thought
18 that this was worth inquiring into 'so
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20 with all the necessary action that the
21 state alone can take, taken by it, with
22 room left for action by the individual
23 for himself'".

24 Mr. Chairman, these are warnings that
25 doctors and people who are responsible for the provision
26 of medical services should recognize.

27 COMMISSIONER FIRESTONE: I believe you
28 have emphasized the need for additional medical manpower,
29 well-trained: would your Association, therefore, be in
30 favour of a more comprehensive scholarship system to
attract young students to the Medical School of the
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4 DR. TRUEMAN: Yes, I think this must be
5 qualified too: at the University of Manitoba there are
6 available for medical students scholarships and bursaries,
7 but it will interest you to know that all the scholarships
8 and all the bursaries are not used. The bursaries involve
9 some limitations or controls which require that the
10 graduate practise in the province following his graduation.
11 Possibly for this reason these bursaries are all not used,
12 so perhaps some alternative method of financing medical
13 students is necessary.

14 THE CHAIRMAN: Does that mean practise
15 anywhere in the province?

16 DR. TRUEMAN: They are encouraged under
17 some of the bursaries to practise in rural areas. It
18 has been suggested that loans be made to medical students
19 which would be interest-free and could be repaid after
20 graduation, but the presence of such loans should be
21 made early in a person's education -- perhaps in high
22 school or in their arts and sciences course, so that
23 they would know there was a means of financing the medi-
24 cal course without extraordinary expense. On the other
25 hand, Dr. Gemmell yesterday had a more practical idea;
26 namely, to make sure that medical students in the more
27 senior years at any rate, should be kept close to the
28 sources of their information, namely, the medical school
29 in research capacities or teaching hospitals in some
30 other capacity, and be paid an appropriate salary which
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3 into specialties and do post-graduate work.

4 This matter is close to Dr. Cooke's heart,
5 and perhaps he could amplify this somewhat.

6 DR. COOKE: Mr. Chairman, we are competing
7 in an expanding economy with science and business and
8 industry for able young people, and it is increasingly
9 difficult to attract them to medicine. Today there is
10 a reason not to pursue higher education in our present
11 system, certainly not to pursue it beyond the level of a
12 bachelor's degree. If a young man obtains a Bachelor of
13 Science degree he can expect to earn approximately \$50,000
14 in the next nine years after graduation. Why should he
15 go on to take a master's degree or a Ph.D. or a fellowship
16 in some specialty? Even if he does, and perhaps earns
17 a higher annual income, he will then come into a higher
18 taxation bracket, and these facts of economic life
19 perhaps dissuade some young people from pursuing higher
20 education, not only in medicine but in the sciences and
21 in the humanities. As Mr. McCutcheon remarked, everybody
22 likes to get his income tax lowered, and we wondered if
23 the Commission would consider the possibility of making
24 the cost of higher education beyond the bachelor or four-
25 year level an income tax deductible item? This would
26 encourage young people to go into master's and Ph.D. and
27 various specialties. We wish to emphasize such a sugges-
28 tion for income tax deduction would apply to all fields
29 of education. Such a measure would be more in character
30 with a self-reliant and competent free enterprise society
and would encourage young people to borrow money, and
the ambitious student would be more likely to borrow



into specialties and do post-graduate work.
This matter is close to Dr. Cooke's heart,
and perhaps he could amplify this somewhat.

in an expanding economy with science and business and
industry for able young people, and it is increasingly
difficult to attract them to medicine. Today there is
a reason not to pursue higher education in our present
system, certainly not to pursue it beyond the level of a
bachelor's degree. If a young man obtains a bachelor of
Science degree he can expect to earn approximately \$50,000
in the next nine years after graduation. Why should he
go on to take a master's degree or a Ph.D. or a fellowship
in some specialty? Even if he does, and perhaps earns
a higher annual income, he will then come into a higher
taxation bracket, and these factors of economic life
perhaps dissuade some young people from pursuing higher
education, not only in medicine but in the sciences and
other fields.
The Commission would consider the possibility of making
the cost of higher education beyond the bachelor or four-
year level an income tax deductible item. This would
encourage young people to go into master's and Ph.D. and
various specialties. We wish to emphasize such a sugges-
tion for income tax deduction would apply to all fields
of education. Such a measure would be more in character
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4 money and go on if he knew he could pay it back out of
5 his earnings. This would also allow universities to
6 charge a more realistic fee, and it would therefore
7 lessen the dependency of universities on the public purse.

8 COMMISSIONER FIRESTONE: Would the Manitoba
9 Medical Association support a plan, possibly maintained
10 by the Federal Government, which would involve the
11 guarantee of the chartered banks on loans made to students
12 without any conditions? This would cover all students
13 including medical students.

14 DR. TRUEMAN: Yes.

15
16 --- Short Recess

17 COMMISSIONER FIRESTONE: Dr. Trueman, if
18 I may turn to No. 4: "That within his competence, each
19 physician has the privilege to treat his patients in and
20 out of hospital". Could you elaborate what you mean by
21 "the privilege"?

22 DR. TRUEMAN: Mr. Chairman, the competence
23 of the doctor is determined by his academic qualifications
24 which in turn are judged by the College of Physicians and
25 Surgeons of the province which provides the doctor with
26 his licence, and this licence gives the doctor very wide
27 powers of practice, and as a result by law a doctor may
28 undertake any procedure whether or not he has had special
29 qualifications to undertake that procedure. Now, hospitals
30 determine the rights or privileges of a doctor to treat
his patient in the hospital according to his ability.
Therefore, all hospitals will seek to regulate the type



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DR. TRUENMAN: Yes.

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5 upon his qualifications, whether they are the qualifica-
6 tions obtained through his degree in medicine, or whether
7 they are by wider qualifications as determined by his
8 post-graduate work and Royal College of Physicians and
9 Surgeons of Canada or the equivalent.

10 DR. RABSON: I would like to carry that
11 answer further, if I may, Mr. Chairman. In England it
12 has been the practice, which has now been rectified,
13 that general practitioners do not follow their patients
14 into the hospital. In the British Medical Journal of
15 1961 -- I think of February -- you will find reports by
16 three doctors that the general practitioners of England
17 sent to Canada, Free Europe and the United States, and
18 it is their opinion that the competence of the average
19 general practitioner in these countries, particularly in
20 Canada, was much higher than that of England because the
21 doctors attended the hospitals and all the teaching
22 facilities that the hospital provided for them.

23 THE CHAIRMAN: I don't want to enter into
24 a discussion with the early part of your answer, Dr.
25 Trueman, but I think I have to accept it with some
26 qualifications when you stated what was the law.

27 DR. TRUEMAN: This is your judgment, sir,
28 and I will accept it.

29 COMMISSIONER FIRESTONE: May I have your
30 advice on a problem which one practising Manitoba physi-
cian was telling me just the other day? He was practising
in a rural riding and was called in to see a patient who
was in receipt of an old-age pension of \$55. The



of work that physicians undertake, basing this decision upon his qualifications, whether they are the qualifications obtained through his degree in medicine, or whether they are by wider qualifications as determined by his post-graduate work and Royal College of Physicians and Surgeons of Canada or the equivalent.

DR. RASBON: I would like to carry that answer further, if I may, Mr. Chairman. In England it has been the practice, which has now been rectified, that general practitioners do not follow their patients into the hospital. In the British Medical Journal of 1961 -- I think of February -- you will find reports by three doctors that the general practitioners of England sent to Canada, Free Europe and the United States, and it is their opinion that the competence of the average general practitioner in these countries, particularly in Canada, was much higher than that of England because the doctors attended the hospitals and all the teaching facilities that the hospital provided for them.

THE CHAIRMAN: I don't want to enter into a discussion with the early part of your answer, Dr. Trueman, but I think I have to accept it with some qualifications when you stated what was the law, and I will accept it.

COMMISSIONER FIRESTONE: May I have your advice on a problem which one practicing Manitoba physician was telling me just the other day? He was practicing in a rural riding and was called in to see a patient who was in receipt of an old-age pension of \$55. The



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3 physician found this man was suffering from virus pneu-
4 monia. If he were to subscribe aureomycin it would cost
5 the patient \$16 for 20 pills and the patient would take
6 about five days to take the pills at four pills a day.
7 This particular patient could not afford to pay \$16; all
8 he was getting was \$55 a month, and the doctor felt the
9 man needed help, so the only alternative he could see
10 was to put him into a nearby hospital. There the man
11 stayed five or seven days and got his drugs, and to put
12 the man into hospital would have cost the Province of
13 Manitoba and the taxpayer of Canada something like \$20 a
14 day for a total of \$100 or \$140. So, in order to save
15 the man \$16, which he didn't have, the people of Manitoba
16 and the taxpayers of Canada paid between \$100 and \$140.
Would you think that is an efficient system?

17 DR. TRUEMAN: No, that is not an efficient
18 system, and there should be an agency -- and there are
19 agencies whereby the doctor would be able to obtain the
20 medicine without charge to that patient.

21 DR. RABSON: Our plan advocates that the
22 old-age pensioners coming under -- where the hospital
23 treatment is waived, and he has complete help in getting
total help.

24 DR. TRUEMAN: If, according to our plan,
25 such a patient -- and this is an old-age pensioner who
26 no doubt required that his hospital service premium be
27 waived -- in our consideration of coverage we feel that
28 Medicare as it exists now should be extended to include
29 this type of patient, in which case he would receive his
30 pharmaceutical supplies without charge through the agency



physician found this man was suffering from virus pneumonia. If he were to subscribe aureomycin it would cost the patient \$16 for 10 pills and the patient would take about five days to take the pills at four pills a day. This particular patient could not afford to pay \$16; all he was getting was \$25 a month, and the doctor felt the man needed help, so the only alternative he could see was to put him into a nearby hospital. There the man stayed five or seven days and got his drugs, and to put the man into hospital would have cost the Province of Manitoba and the taxpayer of Canada something like \$25 a day for a total of \$100 or \$125. So, in order to save the man \$16, which he didn't have, the people of Manitoba and the taxpayers of Canada paid between \$100 and \$125.

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3 of government.

4 COMMISSIONER FIRESTONE: Let us substitute
5 the old-age pensioner and assume he is a man who has been
6 laid off and lost his job and has a wife and two children
7 and gets a minimum of unemployment insurance and cannot
8 afford the \$16; how would you solve his problem?

9 DR. TRUEMAN: If it were my problem I
10 would be in touch with the social service agency at the
11 Winnipeg General Hospital and through that agency, and
12 perhaps the Homemakers' Program there, the necessary
13 medication would be provided for that patient without
14 too much delay.

15 COMMISSIONER FIRESTONE: In other words,
16 you are saying it is much more efficient to devise a
17 system that will provide these drugs rather than put
18 patients into hospital, which would be a much more costly
19 operation?

20 DR. TRUEMAN: That is so, sir.

21 COMMISSIONER FIRESTONE: Would your Association
22 be in favour of a prepaid drug scheme?

23 DR. TRUEMAN: You must understand that we
24 have had no experience with a prepaid drug scheme, but if
25 a properly administered prepaid drug scheme could be
26 established, I am sure that we would agree that was a
27 good thing.

28 COMMISSIONER FIRESTONE: Thank you, Dr.
29 Trueman; that is a forthright and helpful answer.

30 No. 5: "That each individual physician is
free to select the type and location of his practice".
We have heard there has been a little difficulty in



of government.

COMMISSIONER FIRSTONE: Let us substitute the old-age pensioner and assume he is a man who has been laid off and lost his job and has a wife and two children and gets a minimum of unemployment insurance and cannot afford the \$18: how would you solve his problem?

DR. TRUEMAN: If it were my problem I would be in touch with the social service agency at the Winnipeg General Hospital and through that agency, and perhaps the Homemakers' Program there, the necessary medication would be provided for that patient without too much delay.

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4 persuading some physicians to practise in areas outside
5 Greater Winnipeg. I understand why people like to live
6 in Greater Winnipeg, but what can be done to encourage
7 some physicians to provide some minimum of medical
8 service in the rural areas?

9 DR. TRUEMAN: Well, Mr. Chairman, again I
10 would like to qualify this by saying that in Manitoba,
11 especially south of the 53rd parallel, there are few,
12 if any, communities without the service of a doctor, and
13 those that would like to have a doctor, and which cannot
14 support a doctor in the area under consideration are
15 within relative easy access either through road or tele-
16 phone with a nearby doctor. Now, doctors in Manitoba,
17 like doctors elsewhere in North America, are becoming
18 increasingly interested in group practices or alliances,
19 and this is happening in rural Manitoba where doctors in
20 adjacent towns are combining themselves together for
21 their own benefit and for the benefit of patients. They
22 are making use of perhaps the best hospital in the centre
23 of that locale, and by exercising the facilities or
24 functions of that hospital they are improving those faci-
25 lities to the satisfaction of themselves and to the
26 patients whom they treat.
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4 If this is extended further there will be less tendency
5 for patients to be there so as to receive more specialized
6 service this way. Now, this is a fact, it is happening
7 and it has happened in a fairly or relatively large number
8 of areas. This tendency has been supported by the fact
9 that through the use of the Federal health grants the
10 Government of Manitoba has established diagnostic units
11 in six areas in the province beyond Winnipeg and Brandon
12 and these areas meet the needs of something like 165,000
13 people in the province. If I may use this figure for a
14 minute, Mr. Chairman, I would like you to understand that
15 among 350,000 people whom Mr. Roblin described as not
16 being covered by medical insurance in the province,
17 165,000 of them have access to these diagnostic centres
18 so that their need for medical insurance is not as urgent
19 or as desirable as it might be for people in Winnipeg.
20 This takes care, I think, of the problem of a large part
21 of that 350,000 people described yesterday.

22 Now, the first part of the answer, Mr.
23 Firestone, is what you wish to hear.

24 DR. RABSON: We have not been remiss in
25 our responsibility in this matter. Three years ago we
26 set up a series of lectures and meetings with fourth-year
27 medical students whereby we have a general practitioner
28 from the country talk to them on how to set up a practice.
29 We have a bank manager or a chartered accountant who
30 shows them the difficulties and we try to paint a picture
of country practice. I think in some cases they induce
young men to go to these areas.

DR. TRUEMAN: Or to go a bit further if

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4 you wish and indicate that it is proper in isolated
5 areas where a doctor is required and where the economics
6 of that area do not permit support of such a doctor that
7 some authoritative agency should be in a position to make
8 it possible, through remuneration in the form of a salary,
9 to bring a doctor to that area.

10 Another suggestion has been that those
11 areas at some distance from the larger centres could
12 perhaps attract doctors by making available to them some
13 home accommodation and perhaps office accommodation and
14 arrange through the hospital zone in which these towns
15 are situated the privilege of using the nearby hospital.
16 It goes like that. I think efforts are being made to
17 cover the requirements of the people in the rural areas.

18 COMMISSIONER FIRESTONE: Thank you.
19 Principle 7, you refer to the fact that the duty of the
20 physician to his individual patient takes precedence over
21 his obligation to any medical services insurance programs.
22 Have you had any experience or an example to give us of
23 a conflict of interest in operating the Manitoba Medical
24 Service plan?

25 DR. RABSON: I do not think we have, Mr.
26 Chairman, any concrete examples but it is possible that
27 it might occur where a doctor feels that the prorating
28 does not meet his requirement and he may want to limit
29 the service in order to make the program work. That is
30 possible. This principle merely suggests that an obligation
to his patient is far greater than his obligations
to any program.

DR. TRUEMAN: As I think this over, I

you wish and indicate that it is proper in isolated areas where a doctor is needed and where the economics of that area do not permit support of such a doctor that some authoritative agency should be in a position to make it possible, through remuneration in the form of a salary, to bring a doctor to that area.

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DR. FREEMAN: As I bring this over, I



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3 think it was answered earlier by myself when we were
4 dealing with the matter of compulsion. One of the first
5 things I said was the duty of the doctor is primarily to
6 his patient. I feel principle 7 here has in mind the
7 possibility that the compulsory scheme and the control
8 of the medical services - the benefits which may be
9 required by the patient and yet not made available by this
10 compulsory scheme.

11 COMMISSIONER FIRESTONE: Are you suggesting
12 that a compulsory scheme would affect the quality of the
13 service?

14 DR. TRUEMAN: Yes sir, I am.

15 COMMISSIONER FIRESTONE: I would like to
16 go back to this point later because you have a quotation
17 in your supplementary brief and I would like to question
18 around the quotation. I shall go back to that later.

19 We now turn to principle 7 in which you
20 say:

21 "That every resident of Canada, whether
22 a recipient or provider of services,
23 has the right of recourse to the courts
24 in all disputes".

25 Would recourse to the courts be the only
26 way to go about it? Would you accept, for instance,
27 recourse to a board of arbitration where you do not have
28 to follow strict procedures?

29 DR. TRUEMAN: No, I am sure where issues
30 arise and I am limiting it to those areas between a
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4 Physicians and Surgeons whereby a patient with a complaint
5 can be heard by medical authorities in which case - this
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8 some justice rendered to the patient. On the other hand,
9 there is no doubt about it that where a doctor is under
10 pressure from a patient because of some misfortune which
11 has happened to the patient as a result of treatment
12 whether it was due to neglect or accident, that in such
13 a case the patient or the doctor may bring this problem
14 to the court for resolution.

15 DR. RABSON: The preliminary part of these
16 principles says that we would be willing to work under
17 medical insurance programs which observe these principles.
18 I think I am right, subject to correction by the Chairman,
19 that under the Workmen's Compensation Board there is no
20 appeal to the courts, I think the decision of the Board
21 is final. That is my impression and this is the sort of
22 thing we feel should not be.

23 THE CHAIRMAN: In some provinces.

24 DR. RABSON: Well, I think it is true in
25 this province. We feel this should not be the circum-
26 stances under which one should work under the medical
27 insurance program.

28 COMMISSIONER FIRESTONE: Principle No. 9
29 provides that medical service insurance programs do not
30 in any way preclude the private practice of medicine.
Now, under the Manitoba Medical Service program is the
private practice of medicine precluded?

the Manitoba Medical Association and the College of Physicians and Surgeons whereby a patient with a complaint can be heard by medical authorities in which case - this does not happen very often - the complaint of the patient may be upheld by the doctors' peers and as a consequence some justice rendered to the patient. On the other hand, there is no doubt about it that where a doctor is under pressure from a patient because of some misfortune which has happened to the patient as a result of treatment whether it was due to neglect or accident, that in such a case the patient or the doctor may bring this problem to the court for resolution.

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provides that medical service insurance programs do not in any way preclude the private practice of medicine. Now, under the Manitoba Medical Service program is the private practice of medicine precluded?



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4 DR. TRUEMAN: No, it is not; neither from
5 the standpoint of the patient nor the standpoint of the
6 doctor.

7 COMMISSIONER FIRESTONE: Now, if the
8 income of the Manitoba Medical Service consisted of
9 payments made to the medical services by governments
10 instead of premiums, would you feel that - otherwise no
11 change in the arrangements you have now - would you feel
12 this in some way precludes the private practice of medi-
13 cine?

14 DR. TRUEMAN: Yes, I do, sir.

15 COMMISSIONER FIRESTONE: Why, sir?

16 DR. TRUEMAN: Well, I hear a number of
17 people wishing to answer this one.

18 DR. RABSON: We feel certain if the Govern-
19 ment were to install this new service for all health
20 services that the private practice of medicine could be
21 included. In England the private practice of medicine
22 is not stopped but if you go to a doctor not on the panel
23 and he writes a prescription then you get the drugs by
24 payment of a small deterrent fee. However, if you go to
25 a private doctor you pay the full cost of the prescription.
26 This is one method by which the private practice of medi-
27 cine could be precluded and we feel this could happen
28 either directly or indirectly.

29 COMMISSIONER FIRESTONE: Even though the
30 Manitoba Medical Service would be left to proceed with
31 its operations on the basis that the physicians would
32 have the major say and some government offices on the
33 Board, it would be very debatable how long that would last.



DR. TRUMAN: No, it is not; neither from

the standpoint of the patient nor the standpoint of the doctor.

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COMMISSIONER HIRSTON: Why, sir?

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DR. HIRSTON: We feel certain if the govern-

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COMMISSIONER HIRSTON: Even though the



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4 DR. RABSON: Blue Cross is doing a very
efficient job and I think their future has been decided.

5 COMMISSIONER FIRESTONE: In principle No.
6 10 you say that medical research, undergraduate and
7 post-graduate teaching are not inhibited by any medical
8 services insurance program. Can you describe circum-
9 stances under which such a fear could be realized?

10 DR. TRUEMAN: Yes, I think I can do that.
11 Under the Manitoba Hospital Services Plan the budgets
12 of hospitals, not only ordinary general hospitals but
13 teaching hospitals, are controlled by the Plan. The
14 teaching hospitals are especially interested in the
15 maintenance of a program for medical research and for
16 post-graduate teaching as well as undergraduate teaching.
17 These are expensive matters and require funds for research
18 and salaries and support for the post-graduate students
19 and, therefore, it is a question as far as Manitoba
20 Hospital Services Plan is concerned whether it is respon-
21 sible to support or maintain this program. Their respon-
22 sibility is chiefly for the provision of medical services
23 for patients admitted to the hospital and beyond that,
24 and a nominal interest in medical services by residents
25 and internes, they have no particular interest. Because
26 the budget may be limited from the amount of money
27 available to the plant then these research projects,
28 residency training programs, are restricted. Now, if
29 this is so and perhaps this is right then there must be
30 some other way of providing the funds to carry on these
programs. One would then favour that any medical service
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3 provision for making possible these services or that
4 some alternative way of paying for the services could
5 be found. We would suggest this perhaps is not agreeable
6 to everybody in the Faculty of Medicine or the Manitoba
7 Medical Association but that possibly these programs
8 which are so essential to the progress of medicine and
9 to the provision of specialists and other doctors in
10 this province that maybe the Government should provide
11 this money through the university which then would have
12 an increasing responsibility in the post-graduate
13 training courses and the research programs undertaken
14 in the hospitals.

15 COMMISSIONER FIRESTONE: Thank you. In
16 principle No. 11 you suggest that any Board, Commission
17 or agency set up to administer any medical services
18 insurance program has fiscal authority and autonomy.
19 Could you elaborate, please?

20 DR. TRUEMAN: I turn this over to our
21 economics department.

22 DR. RABSON: Mr. Chairman, in our previous
23 discussion on compulsion, one of the things that we
24 felt had been accepted in other countries where compulsion
25 on this type of program was in effect was that the plans
26 are made to fit the budgets which are already set up.
27 We say that this is wrong in the profession of health
28 services. Now, if you study the School Board of Canada
29 I think in most provinces a School Board has fiscal
30 authority and autonomy. The School Board sets up the
requirements for education in that area, says how much
money it needs to the council involved and the council



provision for making possible these services or that
some alternative way of paying for the services could
be found. We would suggest this perhaps is not agreeable
to everybody in the Faculty of Medicine or the Manitoba
Medical Association but that possibly these programs
which are so essential to the progress of medicine and
to the provision of specialists and other doctors in
this province that maybe the Government should provide
this money through the university which then would have
an increasing responsibility in the post-graduate
training courses and the research programs undertaken
in the hospitals.

COMMISSIONER FIRESTONE: Thank you. In

principle No. 11 you suggest that any board, Commission
or agency set up to administer any medical services
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Could you elaborate, please?
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4 has to vote the money on their behalf. There have been
5 recent attempts in this area to wrest this authority
6 away and we feel any committee set up should have this
7 fiscal authority and have some say on how much it will
8 cost in order to have the health services set up the
9 way they should be.

10 COMMISSIONER FIRESTONE: Would it also
11 say where the money should come from?

12 DR. RABSON: That would depend on the
13 terms of reference under which your Board was set up.

14 COMMISSIONER FIRESTONE: We are interested
15 in your idea of placing the authority; how far it goes.

16 DR. RABSON: I think it could be said that
17 this is the sort of Board that would be set up under
18 government auspices and they should have fiscal authority.

19 COMMISSIONER FIRESTONE: Would it be
20 advisory or administrative or perform both functions?

21 DR. RABSON: Both functions.

22 COMMISSIONER FIRESTONE: Principle No. 12
23 you say the medical profession should be represented on
24 any Board, Commission or agency. Now, if you had the
25 present Manitoba Medical Service and the Board of Trustees
26 and there was added to it six government officials
27 because there is Federal and Provincial or Federal or
28 Provincial contributions to these funds, would you feel
29 the medical profession would still be adequately repre-
30 sented on such a Board?

DR. TRUEMAN: Yes. As it exists now you
know there are 16 medical members and 8 lay members and
the addition of six other lay members would be welcome,



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4 COMMISSIONER FIRESTONE: Even though the
5 other lay members are government representatives?

6 DR. TRUEMAN: That perhaps would be all
7 the better.

8 COMMISSIONER FIRESTONE: In principle 13
9 you say that members of the medical profession as the
10 providers of medical services have the right to determine
11 the method of their remuneration. How does the medical
12 profession currently work out payments it is to receive
13 from the Government of Manitoba for work done, services
14 rendered under the Medicare program?

15 DR. TRUEMAN: This was determined by
16 negotiation between the Government of Manitoba and the
17 Manitoba Medical Service. A premium was struck and it
18 has been the premium paid by the Government into the
19 Manitoba Medical Service for the services rendered to
20 Medicare patients by the doctors who are medical members
21 of the Manitoba Medical Service.

22 COMMISSIONER FIRESTONE: In other words,
23 you are suggesting the principle of the right to determine
24 the method does not preclude negotiations with the Govern-
25 ment?

26 DR. TRUEMAN: Certainly not.

27 COMMISSIONER FIRESTONE: It is not an
28 exclusive right?

29 DR. TRUEMAN: No.

30 COMMISSIONER FIRESTONE: In principle 14
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3 acting on their behalf. I take it that those acting
4 on their behalf would include government?

5 DR. TRUEMAN: Yes.

pw 6 COMMISSIONER FIRESTONE: Thank you very
7 much. May I now turn to paragraph 5 of the supplementary
8 brief, on page 3, in which you contend that the source
9 of funds affects the quality of care, and I quote: "If
10 funds come entirely from a central authority which of
11 necessity then exercises complete control over the provi-
12 ders of medical care, the quality of care declines".
13 You quote as a reference a study published by the Univer-
14 sity of Michigan. Would you explain to us how the control
15 over the providers of medical services would affect the
16 quality of care?

17 DR. RABSON: Well, I think the very fact
18 that there was financial control by a third party would
19 definitely affect the quality of care. This was the
20 point I was trying to make when I said the ease with
21 which ceilings could be put on expenditures ---

22 COMMISSIONER FIRESTONE: Let us assume,
23 sir, we have the Manitoba Medical Service continue opera-
24 ting as it does at the moment, but the funds are coming
25 from a Government source. In what way would this affect
26 the quality of service?

27 DR. RABSON: This wouldn't affect the
28 quality of service as long as this relationship were
29 maintained. I think we have made this point before, that
30 if the Government were the sole custodian of funds, or
the sole customer of the Manitoba Medical Service, it
would not be long before it was taken over. We are

acting on their behalf. I take it that those acting

on their behalf would include Government?

DR. TRUENAW: Yes.

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3 referring to experience and observation.

4 COMMISSIONER FIRESTONE: Can you give the
5 Commission the benefit of such experience and observation?

6 DR. RABSON: I think the Blue Cross is the
7 best example we can think of as far as the doctors were
8 concerned, it was a good service, it had some limitations
9 and restrictions, and it was taken over. I think this
10 service as a voluntary thing might have been extended
11 quite satisfactorily, and without limitations.

12 THE CHAIRMAN: That was for hospitalization.

13 DR. RABSON: For hospitalization.

14 COMMISSIONER FIRESTONE: Could we have
15 your advice on medical care if we can come to the point
16 with which you are most familiar?

17 DR. COOKE: Regarding the source of the
18 funds it is interesting to compare the United Kingdom
19 with North America. In the United Kingdom there is a
20 central authority which allocates a fixed budget. We
21 have heard stories of the rising cost of medical care in
22 Great Britain. According to Professor Lees, it has now
23 fallen to below 4% of the gross national product. This
24 is a consideration when the Government allocates funds
25 to health, defence and so on. Compare this with the
26 situation in North America, where the individual citizen
27 makes the decision as to whether to buy a television set,
28 or visit the doctor, or go away for the weekend. The
29 amount of money spent in the United States of America has
30 risen to almost 5% of the gross national product. This
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4 see remain in the hands of the citizens who are self-
5 responsible and self-reliant.

6 COMMISSIONER FIRESTONE: If you, as a
7 doctor, received your payment for services rendered to
8 your patient from the Manitoba Medical Service, and if
9 this money originally came from the Government instead
10 of from premiums, would you in any way change the quality
11 of the care to the patient who comes to you, the same
12 patient, and you see him year in and year out, would you
13 change the quality simply because the money came from the
14 Government?

15 DR. TRUEMAN: Everything being equal sir,
16 it would seem quite reasonable that that would be a
17 satisfactory arrangement, and I said earlier that condi-
18 tions remaining as they are, it might be quite reasonable
19 to practise under such an arrangement, but time moves on,
20 sir, and the interest of the Provincial Government in
21 maintaining the Manitoba Medical Service through a subsidy
22 provided by the Federal Government, and the element of a
23 voluntary participation in the plan presently suggested,
24 I am sure will give way to a compulsory element becoming
25 involved, and with the dangers which are inherent in a
26 monopoly undertaken by a government without competition.
27 It is not our concern so much with Mr. Roblin's opinion
28 and his suggestions about a medical plan. It is our
29 concern as to what will happen to doctors' services and
30 patients' care in the future, if this type of plan is
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31 COMMISSIONER FIRESTONE: Dr. Trueman, are
32 either you or any of your associates familiar with the

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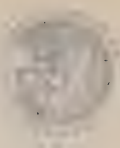
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4 sort of medical care programs in operation in Scandinavian
5 countries, where government-supported programs provide
6 for such services, which are rendered, of course, by
7 participating physicians? If anyone has had such
8 experience, and I see Dr. Rabson nodding his head, would
9 he care to elaborate, and advise us whether there has
10 been any deterioration in the quality of the medical
11 service as a result of the money coming from a government
12 source?

13 DR. TRUEMAN: I will start this, and I am
14 sure Dr. Rabson will be able to develop it further. There
15 are matters in the Swedish method of providing medical
16 care which I do not think would be acceptable at the
17 present time to the people of Canada, and which would not
18 be attractive to the doctors of Canada, or Manitoba.
19 First of all, for some reason or other there is a shortage
20 of doctors in Sweden, and the same applies to Norway, and
21 they are seeking for ever to obtain doctors from other
22 areas, whether these areas be Greece or Italy, or else-
23 where, they are short of doctors. This suggests that
24 this system is not overly attractive. As far as the care
25 of the patient is concerned, the patient attends his
26 general practitioner. If he requires further care and
27 requires hospitalization, he must leave his patient at
28 the front door of the hospital and turn him over to a
29 doctor or surgeon unknown to the patient, and these
30 things I think run contrary to the principles of general
practice as we know them. As far as the economics of the
system are concerned, I am not familiar with them, except
to be able to say that under the Swedish system the fee-



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3 for-service principle is still possible.

4 DR. RABSON: Mr. Chairman, I think the
5 situation in Sweden evolves into the parts Dr. Trueman
6 described, and then if you want free care you go to any
7 hospital dispensary, where usually you are treated by
8 residents in training, but if you go to the doctor's
9 office, you pay your bill and then take it to the Post
10 Office, where you get 75% reimbursement. This is not a
11 plan that all people belong to. This is patients dealing
12 directly with doctors and receiving money for that from
13 the Government. This type of set-up does not lend itself
14 to complete government monopoly quite as easily as the
15 plan previously outlined by yourself. In Switzerland I
16 believe, and I am sure you are familiar with this, they
17 have this canton voluntary associations, which pay
18 premiums, and the Government subsidizes them to about 10%
19 if they meet certain requirements. This is the form of
20 government subsidy which we feel should be looked for.
21 With regard to government subsidy there seems to be some
22 hesitation regarding the subsidization of companies
23 which make a profit providing health care. It seems to
24 me that all throughout the Canadian economy there are
25 subsidies by government to companies which make a profit.
26 There are subsidies to railways, there are subsidies to
27 gold mines and so I don't think this is a principle which
28 has been accepted in our Canadian economy, and if any
29 other carrier than the Manitoba Medical Service can meet
30 the basic requirements which we feel should be set up
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4 DR. COOKE: We have stated that we would
5 be willing to accept a Government member on the Board of
6 M.M.S.; but it is strange to observe that the automotive
7 industry, which hides behind a tariff wall, does not have
8 a Government man on their Board, and the clothing industry
9 that supplies clothing to social welfare does not have a
10 Government man on their Board, so it is strange for us to
11 be selected for this particular target.

12 COMMISSIONER FIRESTONE: Would you not
13 feel that the health of the Canadian people is a pretty
14 important subject, and that if substantial contributions
15 are made by government, they should have some say as to
16 how the money should be used?

17 DR. COOKE: We have said we would accept
18 a gentleman from the Government, but I would like to draw
19 to your attention this inconsistency.

20 COMMISSIONER FIRESTONE: This may be a
21 debatable point, and as the Chairman said we are here
22 to obtain your advice. May I summarize my understanding
23 of what you and your colleagues have been saying, namely,
24 that if the Government were to subsidize a scheme to an
25 increasing extent to what it has done in the past, this
26 would not affect the quality of the services, but if it
27 were to pay the whole expense, received the money either
28 by taxation or premium, it would affect the services, is
29 that correct?

30 DR. TRUEMAN: I think this is a correct
consideration of our stand, Mr. Chairman. We feel that
there are areas, segments, in the population of Manitoba
which require help, and we would encourage the presence of



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5 ment into the provision of medical services will eliminate
6 competition, not only competition between the doctor-
7 sponsored scheme and the private carriers, competition
8 which is of considerable consequence I think in the
9 improvement of services, and finally, if Government takes
10 over more and more of the medical care of the population
11 generally of the province, nothing I am sure will prevent
12 the conclusion being a compulsory scheme as well as a
13 monopolistic scheme, with all the defects we feel are
inherent in such a system.

14 COMMISSIONER FIRESTONE: Thank you Dr.
15 Trueman. May I now turn to paragraph 6, on page 4,
16 still in the supplementary brief. I quote: "In our free
17 enterprise competitive society the consumers, as well as
18 the providers, do now and should continue to exercise
19 control on costs, quantity and quality of medical care".
20 Now, how do the consumers at present control, (a) cost,
21 and (b) quality of service, medical service, and since
22 this is an economic question, if you wish to have your
23 economist, Mr. Barber, contribute to it and enlighten
24 the Commission, as well as anyone else, we would be most
happy to have the information.

25 DR. RABSON: No doubt Mr. Barber can
26 answer this better than I, but let me say firstly that
27 consumers exercise control of the cost because consumers
28 initiate medical care. Doctors never initiate medical
29 care. Doctors may be responsible for second visits, may
30 be responsible for the care ensuing, which involves cost,

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6 how the medical care is carried out. People are much
7 better informed about the quality of medical care than
8 most people believe, and they are very well aware whether
9 they have been examined thoroughly and whether they have
10 been investigated thoroughly, and whether the quality
11 meets with their requirements. I think this is an
12 undebatable fact.

13 DR. TRUEMAN: I don't think Dr. Barber
14 thinks he can contribute to this.

15 COMMISSIONER FIRESTONE: May I just ask a
16 further question of Dr. Rabson? When somebody goes and
17 sees his physician, the fee that is charged is set by the
18 physician, isn't that true?

19 DR. RABSON: Yes.

20 COMMISSIONER FIRESTONE: In what way then
21 did the patient or the consumer determine the cost of
22 that service? He pays what the doctor tells him.

23 DR. RABSON: If he pays a fee to the doctor,
24 in the first place he generally has an idea of what fees
25 run in the type of doctor he is consulting. Also, if he
26 feels the fee is too high, he may dispute it, or he may
27 not pay it.

28 THE CHAIRMAN: Does he know it in advance?

29 DR. RABSON: I don't think he knows in
30 advance for an ordinary office visit, unless he asks.
He certainly knows in advance for major procedures.
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3 experience that patients will ask what it costs, and if
4 it is necessary.

5 COMMISSIONER FIRESTONE: But how does the
6 patient control the cost? He asks the physician what it
7 is going to cost him, and he says \$5. How does he control
8 the cost?

9 DR. RABSON: If he says that before he
10 visits the physician he may say I cannot afford to pay
11 that. This may not interfere with him getting treatment,
12 but he controls costs on any health service by initiating
13 it. Secondly, you find a patient with a rupture and you
14 suggest it be repaired, and the patient controls the cost
15 by either accepting your advice or not as he chooses. He
16 accepts or not your investigative procedure.

17 COMMISSIONER FIRESTONE: How does he
18 control the quality of the service?

19 DR. RABSON: As I say, I think that patients
20 are much better aware nowadays of what quality they should
21 expect from the doctor. They firstly determine quality
22 by the end results of their treatment, but they also can
23 tell whether or not they are thoroughly examined and
24 thoroughly investigated. Patients frequently demand
25 x-rays when they are not necessary, because they know
26 x-rays are used, but more and more people are aware, in
27 my opinion, of the painstaking care which should be taken
28 in the diagnosis of a case, and if they find, as most
29 doctors have experienced, that the doctor they go to does
30 not provide this type of quality, if that is their
opinion, they can easily leave this doctor.

COMMISSIONER FIRESTONE: Paragraph 11,



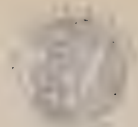
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4 where you have a recommendation for an Accreditation
5 Board to assess what plans should be in receipt of subsi-
6 dies. Now, let us assume such an Accreditation Board
7 exists, and it examines a plan and it finds that this
8 particular plan has cancellation privileges and other
9 conditions in small print, which this Accreditation
10 Board does not find to be acceptable in line of what you
11 consider to be good practice. In such a case you would
12 refuse to accredit this particular carrier, and will say
13 we are sorry, you do not meet the requirements. Now,
14 what would happen to this particular carrier? I presume
15 he would continue to operate, but not be in receipt of
16 subsidies? Do doctors not care whether there are plans
17 in existence which through the conditions printed in
18 small print, or through their practice of undue use of
19 the cancellation privilege do not give the patients the
20 sort of coverage that a patient thinks he requires, and
21 he comes to a doctor and thinks he is covered, and it
22 turns out he isn't, and all kinds of aggravations develop.
23 Are the doctors not interested in acquiring a minimum
24 standard which would determine whether or not a carrier
25 was going to be in receipt of subsidies or not?

26 DR. RABSON: Doctors are very much concerned
27 about this. I have made the statement before that the
28 demand for government intervention is governed by the
29 demands of low income groups, and we agree with that, and
30 we have felt that the relationship of benefits offered to
the premiums charged was a matter for the insurance regula-
tions in the area where this plan is sold.



where you have a recommendation for an Accreditation Board to assess what plans should be in receipt of subsidies. Now, let us assume such an Accreditation Board exists, and it examines a plan and it finds that this particular plan has cancellation privileges and other conditions in small print, which this Accreditation Board does not find to be acceptable in line of what you consider to be good practice. In such a case you would refuse to accredit this particular carrier, and will say we are sorry, you do not meet the requirements. Now, what would happen to this particular carrier? I presume he would continue to operate, but not be in receipt of subsidies? Do doctors not care whether there are plans in existence which through the conditions printed in small print, or through their practice of undue use of the cancellation privileges do not give the patients the sort of coverage that a patient thinks he deserves, and he comes to a doctor and thinks he is covered, and it turns out he isn't, and all kinds of aggravations develop. Are the doctors not interested in acquiring a minimum standard which would determine whether or not a carrier was going to be in receipt of subsidies or not?

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4 Doctors are so much concerned about this that you may
5 know that the Canadian Medical Association has a special
6 committee on prepaid care which has attempted to set up
7 standards that all prepaid care plans should attempt to
8 meet, and I think this demonstrates the doctors' concern
9 about this, and if it is felt this accreditation program
10 should be carried further, I personally would have no
11 objection to it.

12 COMMISSIONER FIRESTONE: Would you say the
13 Manitoba Medical Association would be in favour of
14 control of all commercial carriers to assure a minimum
15 standard of performance?

16 DR. TRUEMAN: No, I don't think such
17 control would be feasible, sir. I think that if the
18 commercial carrier wishes to be in the field they would
19 have to meet the terms set down by the committee of
20 accreditation which we suggest here as an essential in
21 this field. I think such an accreditation committee
22 could be part of the medical services program or picture
23 in the country.

24 COMMISSIONER FIRESTONE: You are aware
25 that the Superintendent of Insurance -- both the Federal
26 and Provincial Superintendents -- exercise a certain
27 control although they have not gone so far as to go into
28 all the terms and conditions unless they run contrary to
29 the legislation. Wouldn't it be desirable to have some-
30 body look at these things as to whether they meet the
31 need or not?

32 DR. TRUEMAN: The function would be
33 possessed by the accreditation committee. The fact there



Doctors are so much concerned about this that you may know that the Canadian Medical Association has a special committee on prepaid care which has attempted to set up standards that all prepaid care plans should attempt to meet, and I think this demonstrates the doctors' concern should be carried further, I personally would have no

COMMISSIONER FIRSTONE: Would you say the Manitoba Medical Association would be in favour of control of all commercial carriers to assure a minimum standard of performance?

DR. TRUENAN: No, I don't think such control would be feasible, sir. I think that if the commercial carrier wishes to be in the field they would have to meet the terms set down by the committee of accreditation which we suggest here as an essential in this field. I think such an accreditation committee could be part of the medical services program or picture in the country.

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3 is an inspector of insurance, I don't think, has led to
4 the provision of the ample benefits that we feel are
5 necessary for low income people in order to give them
6 the full benefits which they receive for the premiums
7 they pay, and we feel there is a defect somewhere in the
8 system. Perhaps through a voluntary system we can
9 improve the situation.

10 DR. COOKE: Mr. Chairman, this suggestion
11 in our brief of the accreditation committee or Board has
12 some factual basis. In our desire to retain a free enter-
13 prise competitive field in the health care business we
14 have learned that the Federal Government of the United
15 States has undertaken to contribute to health care
16 insurance for all Federal civil servants, and there are
17 many thousands of them. What do they do? They drew up
18 some standards and said they would contribute on a 50-50
19 basis to any Federal civil servant buying health care
20 insurance through approved plans, and this is now in
21 operation. In some districts of Michigan the Blue Shield
22 is the popular one, and in Ohio and other parts of the
23 country different carriers have the bulk of the business.
24 Here is working a competitive exercise in the medical
25 care field. On the contrary, one regrets to report that
26 in our country the Federal Government undertook to contri-
27 bute to medical care insurance for the civil servants,
28 and one carrier was selected, and only one carrier is
29 now paid by government funds, so that the civil servants
30 who wish, for instance, to buy Manitoba Medical Service
here are denied the Federal contribution. We would like
to be proponents of this open competitive approach.



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4 COMMISSIONER FIRESTONE: Dr. Trueman,
5 would you explain to us why you would feel that the
6 Accreditation Board could not deal with insurance plans
7 other than those that would be in receipt of subsidies?
8 Why could that Board not also look at all plans and indi-
9 cate whether they meet a minimum standard which is accep-
10 table to the medical profession and which, in your opinion,
11 could provide a minimum coverage for the people of Mani-
12 toba?

13 DR. TRUEMAN: Well, we are concerned, as
14 you know, Mr. Chairman, with the protection and coverage
15 and provision of insurance for medical services for a
16 particular group of people. Beyond the economic abilities
17 of these people we are not so concerned. Those who are
18 better off and more fortunate can afford to determine the
19 nature or the extent of the services which they feel are
20 best suited for their purposes. Our interest then in the
21 Accreditation Board is that the application of its admini-
22 stration to this group of unfortunates who will require
23 the subsidy -- not necessarily unfortunate except inasmuch
24 as they don't have the money today. The function of this
25 committee could very well be extended to cover other
26 plans provided by the commercial carriers, and perhaps by
27 the Manitoba Hospital Service with reference to its major
28 medical offering through the United Health Insurance
29 Company, but presently our thinking is limited to this
30 relatively small segment, this 25% of the population
which requires consideration.

31 COMMISSIONER FIRESTONE: Would you agree
32 that there is a large group of people in the middle
33

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3 income bracket that have one type of coverage or another,
4 and that in a number of cases these people, when they
5 really face serious illness and face cancellation of a
6 policy, find it hard to pay those substantial doctor
7 bills and hospital bills? Wouldn't it be in the interest
8 of both the consuming public and the physicians if there
9 were insurance of the minimum standard, the minimum
10 coverage in all programs?

11 DR. TRUEMAN: That is reasonable.

12 COMMISSIONER FIRESTONE: If it were
13 desirable, could we have any views whether the Medical
14 Association of Manitoba would be willing to participate in
15 the development of such standards and perhaps participate
16 in a Board?

17 DR. TRUEMAN: Yes, I think this is already
18 demonstrated by the suggestion we make about the accredi-
19 tation committee and the fact -- well, I would like to
20 put it this way: that the Manitoba Division of the
21 Canadian Medical Association was responsible for the
22 setting up of a committee in the Canadian Medical Associa-
23 tion for this very purpose. So, this is not a new idea
24 so far as we are concerned, but one we have pursued for
25 several years.

26 COMMISSIONER FIRESTONE: I take it you
27 would be prepared to extend the program also to the
28 middle income brackets?

29 DR. TRUEMAN: Yes.

30 COMMISSIONER FIRESTONE: Now I come to my
last question. In paragraph 15 and subsequent paragraphs
of your supplementary brief you set out an outline of the

income bracket that have one type of coverage or another, and that in a number of cases these people, when they really face serious illness and face cancellation of a policy, find it hard to pay those substantial doctor bills and hospital bills? Wouldn't it be in the interest of both the consuming public and the physicians if there were insurance of the minimum standard, the minimum coverage in all programs?

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4 proposed plan to take care of (1) people in the welfare
5 categories and (2) you speak of subsidy arrangements for
6 families below certain income levels which you consider
7 as indigent, and you have set out these income levels
8 depending on the size of the family. I notice that a
9 person, according to that schedule on page 7, a family
10 of two adults and two children would be in receipt of
11 that subsidy if their income does not exceed \$2,800.

12 Let us take a family of two adults and two children, and
13 this man is a workman who earns \$60 a week; that is,
14 \$3,000 a year. He loses his job. What happens to his
15 medical care services? Have you provided for him in
16 your proposal?

17 DR. TRUEMAN: We feel, sir, that if
18 through some dislocation of employment a patient is
19 unable to maintain his earnings, and therefore is unable
20 to meet the premiums required by his participation in
21 the insuring agency which he is interested in, whether it
22 be the Manitoba Medical Service or other, that there
23 should be some method of protecting this man. So far the
24 only mechanism which we can suggest is that if his period
25 of unemployment is so lengthy that he then requires to
26 obtain assistance from social welfare agencies, that as
27 he does this it would become known that he is also lacking
28 his medical coverage, and in which case we would suggest
29 under present circumstances as of today that this patient
30 be included in Medicare.

31 DR. RABSON: There is another thing: we
32 have said if such a man turns up in a doctor's office,
33 the doctor will certainly give him service; but there is



proposed plan to take care of (1) people in the welfare categories and (2) you speak of subsidy arrangements for families below certain income levels which you consider as indigent, and you have set out these income levels depending on the size of the family. I notice that a person, according to that schedule on page 7, a family of two adults and two children would be in receipt of that subsidy if their income does not exceed \$2,800. Let us take a family of two adults and two children, and this man is a workman who earns \$80 a week; that is, \$3,000 a year. He loses his job. What happens to his medical care services? Have you provided for him in your proposals?

DR. TRUIMAN: We feel, sir, that if

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4 problem it would become apparent that the unemployment
5 allotments do not include provision for medical services
6 insurance, and possibly they should be increased. This
7 is another way it could be attacked. This is interesting
8 you should mention unemployment, because I think there is
9 a corollary between what we have suggested and unemploy-
10 ment. Unemployment insurance is only compulsory for
11 people below a certain income group, and this is the
12 principle observed in many sectors of our community
13 where certain groups who need help get it.

14 COMMISSIONER FIRESTONE: I would like to
15 say, Dr. Trueman, you and your colleagues have been
16 extremely helpful, and your constructive and forthright
17 answers to the questions and the material and advice you
18 have offered us will be carefully considered, and it has
19 been particularly helpful to us.

20 DR. TRUEMAN: Thank you, Mr. Chairman.
21 I am not sure whether this is the termination of this
22 consideration or not...?

23 COMMISSIONER VAN WART: The question I
24 wish to direct to Professor Barber: you were in the room
25 this morning when I asked the question about semi-indi-
26 gents?

27 DR. BARBER: Yes.

28 COMMISSIONER VAN WART: You heard the
29 reply I received?

30 DR. BARBER: Yes. I am not sure I recall
the precise question.

COMMISSIONER VAN WART: Well, anyway, in



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3 your submission in Section 46 you make conclusions and
4 you give us four groups of income levels and state that
5 there should be some subsidization for these groups.
6 Looking through your brief I cannot anywhere find what
7 this represents in the total population of Manitoba.

8 DR. BARBER: Well, I think one answer to
9 that is that our scale of subsidies -- our proposal in
10 Table A covers income levels that correspond fairly
11 closely, and my estimate was that in the Province of
12 Manitoba this would cover about 25% of all families, and
13 22% of single individuals. This is a fairly approximate
14 estimate because there is no precise information, but
15 this was the best estimate I could make.

16 COMMISSIONER VAN WART: It is a very large
17 segment, then, of your population in Manitoba?

18 DR. RABSON: I said this morning the
19 figures that are being compiled, I believe, show this is
20 an average rate for Canada; that about 25% of the people
21 do not pay income tax.

22 DR. BARBER: You don't add the 25 and 22
23 to get 47. If you take the two separate groups -- the
24 families and the individuals -- it is 25 in the case of
25 the family and 22 in the case of the individuals: so,
26 roughly a quarter of the population.

27 COMMISSIONER VAN WART: That doesn't
28 include the so-called indigent at all?

29 DR. BARBER: Yes. These 25% figures,
30 I think, do.

COMMISSIONER VAN WART: The indigent?

DR. BARBER: Yes, it includes all those

your submission in Section 8 you make conclusions and you give us four groups of income levels and state that there should be some subsidization for these groups. Looking through your brief I cannot anywhere find what this represents in the total population of Manitoba. DR. BARBER: Well, I think one answer is that is that our scale of subsidies -- our proposal in Table A covers income levels that correspond fairly closely, and my estimate was that in the Province of Manitoba this would cover about 32% of all families, and 22% of single individuals. This is a fairly approximate estimate because there is no precise information, but this was the best estimate I could make.

COMMISSIONER VAN WART: It is a very large segment, then, of your population in Manitoba? DR. BARBER: I said this morning the figures that are being compiled, I believe, show this as an average rate for Canada, that about 22% of the people do not pay income tax.

DR. BARBER: You don't add the 25 and 22 to get 47. If you take the two separate groups -- the families and the individuals -- it is 32 in the case of the family and 22 in the case of the individuals; so, roughly a quarter of the population.

COMMISSIONER VAN WART: That doesn't include the so-called indigent at all?

DR. BARBER: Yes, those are figures.

COMMISSIONER VAN WART: The indigents? DR. BARBER: Yes, it includes all those



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3 below the minimum income level.

4 COMMISSIONER VAN WART: Have you any per-
5 centage of the number of indigents in the province?

6 DR. BARBER: Well, we do have figures that
7 came out of the Manitoba hospitalization scheme -- the
8 number who have had their premiums waived for hospitaliza-
9 tion, and I haven't worked them out percentage-wise, but
10 I think there were 8,000 families -- roughly 43,000
11 people overall, which is something like 5% -- 4 to 5%.

12 COMMISSIONER VAN WART: That would make
13 about 20% of this class of semi-indigents?

14 DR. BARBER: Yes.

15 MR. HALL: Are the income levels set out
16 in paragraph 18 which we have been referring to deter-
17 mined exclusive of medical costs?

18 DR. BARBER: They are not determined this
19 precisely. If you look in Table I on page 12, there was
20 an "all other" category which could be allocated to cover
21 medical care possibly as well as other costs.

22 MR. HALL: The point I am getting at is
23 that, using the example that we were given a moment ago,
24 you have a family of two adults and two children with an
25 income of \$3,000, and they do not have medical care
26 coverage: they could conceivably have to pay \$500 a year,
27 say, medical bills?

28 DR. BARBER: But they could get M.M.S. for
29 \$12 a month or \$9 a month.

30 MR. HALL: But if they didn't have it...?

DR. BARBER: But this would not be a regular
annual cost. I am setting out a minimum family budget to



COMMISSIONER VAN WART: Have you any person

DR. BARBER: Well, we do have figures that

come out of the Manitoba hospitalization scheme -- the number who have had their premiums waived for hospitalization, and I haven't worked them out percentage-wise, but I think there were 8,000 families -- roughly \$5,000 people overall, which is something like 1/2 to 1/3.

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MR. HALL: The point I am getting at is that, using the example that we were given a moment ago, you have a family of two adults and two children with an income of \$3,000, and they do not have medical care coverage; they could conceivably have to pay \$200 a year, say, medical bills?

DR. BARBER: But they could get M.H.S. for \$12 a month or \$2 a month.

MR. HALL: But if they didn't have it...

DR. BARBER: But this would not be a regular annual cost. I am setting out a minimum family budget to



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3 meet expenditures on the average.

4 MR. HALL: But if in any year they did
5 have that cost, what is the proposal here -- on the
6 suggestion that their income would be reduced to \$2,500?

7 DR. BARBER: Well, these are just designed
8 to meet the ordinary regular expenditures. If your
9 house burns down and you didn't have insurance, you
10 would have a very large loss. I am not quite sure why
11 you are bringing this in.

12 MR. HALL: Well, it may not happen to the
13 same person each year, but if you had a number who did
14 not avail themselves of the medical services, it could
15 recur through the population each year.

16 DR. BARBER: Yes, and I think the Manitoba
17 Medical Association takes the view that people in this
18 area ought to have comprehensive medical insurance --
19 they should not try to meet these costs on an individual
20 basis by accumulating costs. They cannot afford to take
21 these risks because they can be very high for isolated
22 cases.

23 MR. HALL: And you say they ought to have
24 the prepaid medical care?

25 DR. BARBER: Yes. As I understand the
26 attitude of the Manitoba Medical Association, yes.

27 THE CHAIRMAN: That they ought to provide
28 themselves with it?

29 DR. BARBER: Yes, and it ought to be
30 available to them at a cost, subsidized if necessary, so
they can pay it.

MR. HALL: What is your suggestion if

MR. HALL: But if in any year they did

have that cost, what is the proposal here -- on the

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Medical Association takes the view that people in this

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It is the view of the people, and it is the view of the

country.

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THE CHAIRMAN: What they ought to provide

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available to them at a cost, subordinated if necessary, so

they can pay it.

MR. HALL: What is your suggestion is



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2
3 these marginal families do not provide themselves with
4 this care? Have you any suggestions to cover that
5 situation?

6 THE CHAIRMAN: You mean if they are improvi-
7 dent in that respect?

8 MR. HALL: Yes.

9 DR. BARBER: I don't have any specific
10 suggestion.

11 DR. RABSON: Mr. Chairman, in our submission
12 we have suggested this would not occur in the great
13 majority of people, especially through employer contribu-
14 tions where you have a prepaid medical services paid for,
15 and we used the example of the family allowances: money
16 is given to people to spend on children without controls,
17 and we feel the vast majority of people are responsible
and would do so.

18 DR. TRUEMAN: Finally, Mr. Chairman, if
19 such improvident people came seeking health care, there
20 has been a device suggested whereby the doctor recognizing
21 this would refer the matter to the responsible agency
while he would provide the necessary care.

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THE CHAIRMAN: You mean if they are improv-

ment in that respect?

DR. BARRETT: I don't have any specific

suggestion.

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and would do so.

has been a device suggested whereby the doctor recognizing

while he would provide the necessary care.



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4 DR. RABSON: You may be interested in one
5 observation we made during our studies and that is that
6 yesterday it was suggested that the Commission should
7 determine what amount the Government should spend in this
8 field. I think one of the things that is terribly impor-
9 tant to determine and I think a great difficulty for those
10 in the Government to determine is to know when to do
11 things for people and when to trust others to do them.
12 I think that is the big crux of the situation in this
13 field.

14 COMMISSIONER BALTZAN: Just one final
15 question I address to all of you. Is it consistent with
16 the ideals of the medical profession to lower their
17 sights and think in terms of minimal standards of service
18 to the people, a term so often repeated this afternoon?
19 Might I remind you in opposition to that the object in
20 the terms of reference by the Order in Council, and I
21 quote from memory, is for the best possible health
22 services. I think, Mr. Chairman, that will have to be
23 taken as from memory. In other words, I repeat again that
24 the emphasis has been placed on the terms of reference
25 for the minimal standard of service for the people where
26 the ideals speak otherwise through the ages and the object
27 of this investigation or search as explained in the terms
28 of reference and the Order in Council is for the best
29 possible type of health service. What is the reason for
30 getting down to thinking only in terms of the minimal
standards of service for the health of the people?

THE CHAIRMAN: Dr. Trueman and Dr. Rabson:
rather than that you should have to say that you did not



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of our organization is to have the best possible health
services for the people. I think, Mr. Chairman, that will have to be
getting down to thinking only in terms of the min-
standards of service for the health of the people?

THE CHAIRMAN: Dr. Truman and Dr. Rabson:



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3 say that, I am going to say it for you.

4 DR. TRUEMAN: The only time that minimal
5 standards would be acceptable would be when they were
6 proper standards.

7 DR. RABSON: And I should also refer to
8 the first belief of the Medical Association that the
9 highest standards of medical service should be available
10 for everyone and we have endorsed that.

11 THE CHAIRMAN: Dr. Trueman and your
12 associates, we are very grateful to you for the time you
13 put in in the preparation of your submission, the assis-
14 tance you have been to us in the furnishing of the infor-
15 mation. It is manifest that you have spent a lot of time
16 in research and in thinking of the subject and I want to say
17 on behalf of all the Commissioners that we are deeply
18 obliged to you. Thank you.

19 DR. TRUEMAN: If I may just have the last
20 word; first of all, I would like to say in case any
21 impression has been left through our conversation today,
22 I would like to reaffirm that the Manitoba Medical Associa-
23 tion is always willing to discuss with our Government
24 any plan or plans in connection with the provision of
25 medical services or the improvement of medical services
26 for the residents of Manitoba.

27 Finally, I would like to say to you and
28 the Commissioners that we wish to thank you for your
29 very pleasant and courteous reception of our brief and
30 it is our hope and trust that your further deliberations
may be interesting as well as valuable. Thank you, sir.

THE CHAIRMAN: We will proceed with the



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1
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3 submission of the Manitoba Psychiatric Association.
4

5 SUBMISSION OF THE MANITOBA PSYCHIATRIC ASSOCIATION

6 Appearances: Dr. Geo. Sisler
7 Dr. T.A. Pincock
8 Dr. Blake Thomson
 Dr. Gerda Allison
 Dr. John Burch

9 DR. PINCOCK: Mr. Chairman and members of
10 the Commission I would just like to say that you have
11 been presented with an amendment to the appendices of
12 our brief and you will have before you and we would
13 respectfully suggest that pages 54 and 64 of the brief
14 be withdrawn and the new pages substituted therefor.
With your permission I will get down to reading this.

15 This brief by the Manitoba Psychiatric
16 Association (Psychiatric Section of the Manitoba Medical
17 Association and Manitoba Division of the Canadian Psychia-
18 tric Association) is presented separately from the main
19 brief of the Manitoba Medical Association because there
20 are problems unique to the medical specialty of psychiatry,
21 associated with and inherent in the broad scope of psychia-
22 tric practice penetrating as it does the social, educa-
tional and cultural matrix of our society.

23 It is a matter for regret and serious
24 concern that the organization of psychiatric services in
25 Manitoba does not measure up to the modern concepts of
26 effective treatment. Some of the most serious and
pressing problems are:

27 I would like to suggest at this point that
28 we do not consider the Manitoba situation is any different
29 from that which exists across Canada and in the United
30

Submission of the Manitoba Psychiatric Association.

Apparances: Dr. Geo. S. S. S.
Dr. Blake Thomson

DR. WINDOCK: Mr. Chairman and members of

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3 States. We just wish to point out that conditions which
4 have existed in the past both as to personnel to operate
5 the services and facilities in the services do not measure
6 up to the expanding and newer modern concepts of treatment
7 today.

8 A. Concentration of 4,000 mentally ill
9 and mental defective patients in three large, rural,
10 understaffed, over-crowded Provincial Government Institu-
11 tions, far removed from families and home communities.
12 The Manitoba Psychiatric Association believes that
13 planning for the organization of psychiatric services
14 should be aimed at the development of a community service
15 rather than the type of hospital service which has existed
16 in the past. Its views are based on those principles
17 outlined in the third and fifth reports of the Expert
18 Committee on Mental Health of the World Health Organiza-
19 tion (these were published in 1952 and 1956) which are as
20 follows:

21 "Psychiatric patients should be treated
22 as close to their place of residence as
23 possible thereby avoiding social disloca-
24 tion and permitting continuing contact
25 between the patient, his family, his
26 friends and others in his own community.
27 Smaller hospitals rendering comprehensive
28 service and related to general hospitals
29 will permit patients to accept treatment
30 earlier and will lead to a more extensive
involvement of other physicians and other
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4 the mentally ill. Furthermore, the psychia-
5 tric patient will have available, without
6 unnecessary duplication of services, all
7 of the diagnostic and treatment facilities
8 of the general hospital which are necessary
9 for the adequate diagnosis and treatment of
10 psychiatric illnesses. The provision of
11 adequate ambulatory treatment, ranging
12 from consultation through day-care programs
13 and follow-up services, will minimize the
14 need for in-patient treatment and thereby
15 reduce the need for the continuous develop-
16 ment of beds for psychiatric treatment".

17 B. The urban area of Greater Winnipeg,
18 where more than one-half the population of Manitoba
19 resides, has only 161 psychiatric beds in general hospi-
20 tals for short term care, a number which cannot begin to
21 meet the demands, and the paucity of which necessitates
22 transfer of patients requiring longer term treatment to
23 rural mental hospitals.

24 C. Out-patient services, both rural and
25 urban are insufficient to meet patient needs with regard
26 to prevention, diagnosis, treatment, follow-up and rehabi-
27 litation of the mentally ill. In the past decade the
28 Manitoba Provincial Psychiatric Service, in keeping with
29 modern trends, has been increasingly concerned with the
30 provision of community clinics and out-patient services
designed both to treat illness before it is at a stage
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4 In general, these services have been developed as addi-
5 tional responsibilities for the staff of psychiatrists
6 and other personnel in the provincial hospitals at Winni-
7 peg, Selkirk, Brandon and Portage la Prairie. It is
8 submitted that this patient load, even with the aid of
9 post-graduate physicians in training, is excessive.
10 Further, there being only these three hospitals for
11 general psychiatric illnesses, many patients who require
12 hospitalization must obtain it long distances from their
13 homes, thus hindering rehabilitation and prolonging
14 hospital stay. As they move from out-patient to in-
15 patient treatment and back again, they come under the
16 care of different groups of personnel, thereby precluding
17 continuity and consistency of treatment.

18 D. There is severe shortage of psychiatric
19 personnel, there being only 30 qualified psychiatrists
20 in Manitoba, where according to population the number
21 should be a minimum of 90. In the Provincial Mental
22 Hospitals and other Provincial services, there are 36
23 established positions of which 26 are for qualified
24 psychiatrists. Presently there are only 10 qualified
25 psychiatrists in the Provincial service and of these four
26 are engaged almost full time in administrative duties.
27 Most of these have some part-time teaching responsibilities.
28 Of the remaining 19 qualified psychiatrists, two are
29 employed by the Federal Government, four in University
30 teaching posts, the rest in private practice and all
having other responsibilities in varying degrees, i.e.,
University staff appointments, Children's Hospital
appointments and various agency services. (For specific



and other personnel in the provincial hospitals at Winnipeg, Selkirk, Brandon and Portage la Prairie. It is submitted that this patient load, even with the aid of post-graduate physicians in training, is excessive. Further, there being only three hospitals for general psychiatric illnesses, many patients who require hospitalization must obtain it long distances from their homes, thus hindering rehabilitation and prolonging hospital stay. As they move from out-patient to in-patient treatment and back again, they come under the care of different groups of personnel, thereby precluding continuity and consistency of treatment.

D. There is a severe shortage of psychiatrists. In Manitoba, there being only 30 qualified psychiatrists in Manitoba, where according to population the number should be a minimum of 40. In the provincial mental hospitals and other provincial services, there are 26 established positions of which 26 are for qualified psychiatrists. Presently there are only 10 qualified psychiatrists in the Provincial service and of these four are engaged almost full time in administrative duties. Of the remaining 16 qualified psychiatrists, two are employed by the Federal Government, four in University teaching posts, the rest in private practice and all University staff appointments, Children's Hospital appointments and various agency services. For specific



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4 recommendations see Appendix D). There is also a
5 critical shortage of trained para-psychiatric personnel.

6 E. Despite recent improvement in child
7 psychiatric services, there is still an immediate neces-
8 sity for further development and expansion. There is an
9 urgent need for the establishment of suitable residential
10 facilities for psychotic and severely disturbed children.
11 With the exception of a Child Guidance Clinic attached
12 to the Brandon Mental Hospital, the rural areas have a
13 very limited service. Within the Greater Winnipeg area,
14 the Children's Hospital and the Child Guidance Clinic
15 provide diagnostic and treatment services. In the past
16 two years with the appointment of a full-time Director
17 of Psychiatry to the Children's Hospital and the inclusion
18 of the Winnipeg Child Guidance Clinic in the University
19 psychiatric training program, these services have
20 increased considerably, but they are still unable to cope
21 adequately with ever-increasing needs. In-patient
22 psychiatric facilities for children are limited at the
23 present time. With the proposed expansion of the Chil-
24 dren's Hospital a 15 bed psychiatric unit for short term
25 assessment and treatment is contemplated. The more
26 seriously ill children who require long term psychiatric
27 treatment extended over a period of several months to two
28 years are in need of the facilities of a residential
29 treatment unit. This is not available now, but the
30 construction of such a unit for children up to 12 years
of age is being planned in the Medical Centre Area.

Treatment facilities for severely ill
children, too disturbed to be treated in the above



recommendations see Appendix C). There is also a
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4 present time, chronically ill children admitted to the
5 Psychopathic Hospital are often discharged to the
6 community owing to the lack of facilities for their
7 continuing treatment. Such would necessitate the establish-
8 ment of a separate unit, apart from adult psychotic
9 patients, which would provide among other things class-
10 room and playground facilities. (For specific recommenda-
11 tions see Appendix C).
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The newly amended Appendix C is rather brief, and with your permission I would just like to read it.

SERVICES FOR CHILDREN

Out-patient services for emotionally disturbed children should be provided by professionals operating from a base in the regional psychiatric hospital unit. To a limited extent the facilities of the regional general hospital could provide an in-patient diagnostic and treatment service for children. However, the seriously ill would require referral to more highly specialized facilities which should be developed largely in the Greater Winnipeg area.

In Greater Winnipeg there is need for the continued expansion of the services of the Child Guidance Clinic of Greater Winnipeg, and the out-patient facilities at the Children's Hospital and at St. Boniface General Hospital. A specialized pre-school development service should be established at the Children's Hospital. Essential in patient facilities should include the following:

- (a) Approximately a 15-bed diagnostic and short-term treatment unit at the Children's Hospital.
- (b) A 20-bed residential treatment unit for pre-adolescents in the medical centre and in close relationship to the Children's Hospital.
- (c) A psychiatric hospital for adolescents who require prolonged treatment.
- (d) A facility designed to provide care

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should be established at the Children's Hospital. Essen-
tial inpatient facilities should include the following:

- (a) Approximately a 15-bed diagnostic
and short-term treatment unit at the
Children's Hospital.
- (b) A 10-bed residential treatment unit
for pre-adolescents in the medical centre
and in close relationship to the Children's
Hospital.
- (c) A psychiatric hospital for adolescents
who require prolonged treatment.
- (d) A facility designed to provide care



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4 over a period of many years for chroni-
5 cally severely ill children. Such a
6 facility is required apart from those
7 designed for adult psychotic patients.

8 There is required major expansion at both
9 the psychiatric facilities for dealing with children
10 coming before the Courts and of the treatment facilities
11 of the several child care institutions in Greater Winnipeg.

12 F. There has been a marked lack of faci-
13 lities and funds for basic research in mental illness.
14 The meagre funds available have not been fully utilized
15 because of the restrictions imposed on their use. There
16 are no career research workers because of lack of security
17 of tenure in research work. Funds have been available on
18 a year-to-year basis and so research projects have been
19 short term and suffer from the fact that they have to be
20 approved by two or more levels of administration which
21 have themselves, limited contact with the research field
22 or program other than to restrict the expenditure of
23 public funds to the minimum. The unfortunate effect of
24 this is that such research projects as are advanced are
25 at a superficial clinical level, undertaken as a sideline
26 activity by clinicians and are not projects in basic
27 research executed by scientific workers who are not
28 concerned with immediate clinical applications. There is
29 a corresponding lack of long range planning and integra-
30 tion in these efforts. We, therefore, foresee the neces-
sity of establishing research centres with full time
professional workers who should be free from clinical
responsibilities and who should be assured of tenure of

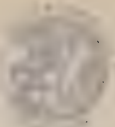
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4 employment and freedom from restriction or the pressures
5 of expediency in the work upon which they embark. There
6 is promise of improvement in this situation, however,
7 with the recent establishment by the Province of the post
8 of Director of Psychiatric Research, as yet unfilled, and
9 increased flexibility of research funds at the Federal
level.

10 3. Certain recommendations are made for
11 the improvement of psychiatric services in Manitoba:

12 A. Attention must be directed towards the
13 problems of recruitment and training of psychiatric
14 personnel by making the specialty more attractive and by
15 expansion of present teaching facilities. The University
16 conducts a recognized post-graduate training program with
17 a capacity to accept five applicants each year, each of
18 these being assigned residencies in both mental hospitals
19 and other settings. To date, this has been barely adequate
20 to cover needed replacements and in point of fact has not
21 satisfied the need in the civil service because of person-
22 nel being drawn into private practice and to points
23 outside the province. In many instances, residents in
24 training are occupying positions which are established
25 for qualified personnel, when in fact, special training
26 positions should be available which are quite apart from
27 these. Insufficient numbers of recent medical graduates
28 are being attracted into the specialty and in order to
29 remedy this, there are two pre-requisites. First, the
30 specialty must be altered so as to attract a greater
number of aspirants. This can undoubtedly be achieved
in considerable measure by attention to details of the



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19 3. Certain recommendations are made for

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17 of Director of Psychiatric Research, as yet unfilled, and

16 of expediency in the work upon which they embark.



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4 kind of practice available, status within the profession
5 and remuneration. Secondly, increase in the facilities
6 for post-graduate psychiatric and para-psychiatric
7 training: a) expansion of present resident training b)
8 augmentation of teaching hospital staffs, therefore
9 better organization of post-graduate teaching in them.

10 B. Gradual reorganization and dispersal
11 of hospital facilities throughout the province, as well
12 as inauguration of some services which are presently
13 either lacking or deficient.

14 Here again I would refer to the brief
15 appendices attached, A and B, Psychiatric Hospital
16 Services, on page 54.

17 PSYCHIATRIC HOSPITAL SERVICES

18 There should be established regional psychia-
19 tric units of 100-200 beds associated with existing
20 general hospitals. As well as in-patient facilities
21 these should have comprehensive day care and out-patient
22 services. They should be designed to serve the psychia-
23 tric needs of the various regions of the province. It is
24 recommended that these units be established in relation-
25 ship to the following hospitals:

26 Winnipeg General Hospital

27 St. Boniface General Hospital

28 Dauphin General Hospital

29 Portage la Prairie General Hospital

30 Proposed General Hospital in St. James

Those units associated with teaching hospi-
tals should have special provision for teaching and
research activities.



of practice available, status within the profession and remuneration. Secondly, increase in the facilities for post-graduate psychiatric and para-psychiatric training: a) expansion of present resident training b) augmentation of teaching hospital staffs, therefore better organization of post-graduate teaching in them.

B. Gradual reorganization and dispersal of hospital facilities throughout the province, as well as inauguration of some services which are presently either lacking or inefficient.

Hence again I would refer to the plan

appendices attached, A and B, Psychiatric Hospital

Services, on page 34.

PSYCHIATRIC HOSPITAL SERVICES

into units of 200-300 beds each, also existing general hospitals, as well as in-patient facilities these should have comprehensive day care and out-patient services. They should be designed to serve the psychiatric needs of the various regions of the province. It is recommended that these units be established in relation ship to the following hospitals:

1. General Hospital, Toronto

2. General Hospital, Hamilton

3. General Hospital, Kingston

4. General Hospital, Ottawa

5. General Hospital, Montreal

These units associated with teaching hospitals should have special provision for teaching and



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4 At the Selkirk and Brandon Mental Hospi-
5 tals there is required renovation and replacement of
6 some of the older buildings. With expansion of out-
7 patient and day care facilities these hospitals should
8 continue to serve as the psychiatric hospital units for
9 the local community. In addition, some beds at the
10 Selkirk and Brandon Mental Hospitals will continue to be
11 required for chronically ill patients needing continued
12 care over a number of years. However, the newly esta-
13 blished regional psychiatric units in other areas of the
14 province with their out-patient, day care and rehabilita-
15 tion services will reduce greatly the number of patients
16 requiring transfer to these larger mental hospitals.

17 In that connection I would like to point
18 out that there has been a trend towards the decrease in
19 the number of resident patients in our mental hospitals.
20 In 1958, in the two large hospitals of Brandon and
21 Selkirk, we had 2,917 patients in residence. In 1961,
22 at the end of the year, we had 2,696, which is a drop of
23 221, and this is a very favourable result of the newer
24 drugs and treatment, and getting patients treated in
25 more community centres.

26 As the provincial population increases,
27 psychiatric hospital needs should be kept under review.
28 The northern regions require special planning because of
29 the population distribution. In the centres at Flin Flon,
30 The Pas, and Thomson, psychiatrists and associated para-
psychiatric personnel could provide out-patient and day
care services and also a limited in-patient treatment in
the regional general hospital, transferring the seriously

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3 ill to psychiatric units in Dauphin and Winnipeg. Such
4 an arrangement should continue until the population of
5 these areas justifies the construction of a regional
6 psychiatric unit.

7 In regard to the total requirement for
8 beds, the generally held estimate has been that of 4
9 beds per 1,000 of population. This figure would suggest
10 that a Manitoba population of 900,000 would necessitate
11 3,600 beds. However, a regional arrangement of psychia-
12 tric services such as that proposed would necessitate a
lower ratio of beds.

13 That is our feeling in view of the trend
14 towards getting patients out of hospital and cutting down
15 on the residual population.

16 This is because of community preventive
17 services, early access to treatment and the avoidance of
18 chronicity induced by hospitalization long distances from
home.

19 It is estimated that these hospital develop-
20 ments will require a capital outlay of \$7,750,000.
21 Operating costs will depend on the per-diem rate at any
22 given time. Even at present inadequate standards of care
23 this would amount to an increase of \$3,925,000 annually
over present costs.

24 APPENDIX "B" - MENTAL DEFICIENCY SERVICES

25 The provision of services for the mentally
26 defective requires the collaboration of health, education
27 and welfare agencies. The requirements for hospital beds
28 are difficult to assess since some patients need a hospi-
29 tal type of care and some require only nursing care.
30



ill to psychiatric units in Guelph and Winnipeg. Such an arrangement should continue until the population of the province is sufficiently small to justify a psychiatric unit.

In regard to the total requirement for

beds, the generally held estimate has been that of 4 beds per 1,000 of population. This figure would suggest that a Manitoba population of 800,000 would necessitate 3,200 beds. However, a regional arrangement of psychiatric services such as that proposed would necessitate a lower ratio of beds.

That is our feeling in view of the trend towards getting patients out of hospital and letting down on the residual population.

This is because of community preventive services, early access to treatment and the avoidance of chronicity induced by hospitalization long distances from home.

It is estimated that these hospital developments will require a capital outlay of \$7,750,000. Operating costs will depend on the per-diem rate at any given time. Even at present inadequate standards of care this would amount to an increase of \$3,925,000 annually over present costs.

APPENDIX "B" - MENTAL DEFICIENCY SERVICES

The provision of services for the mentally defective requires the collaboration of health, education and welfare agencies. The requirements for hospital beds are difficult to assess since some patients need a hospital type of care and some require only nursing care.



Others will benefit from a residential training school setting such as that provided at the Manitoba School at Portage la Prairie with the object of preparation for future adjustment in the community. Many may reside at home if their special educational and social needs can be met.

There is required renovation and expansion of some of the facilities at Portage la Prairie. It is desirable and economical to meet additional bed requirements for this group by utilizing facilities no longer needed for the care of tuberculous patients at the St. Boniface and Ninette Sanitaria.

It is estimated that an increase of approximately 480 beds will be required in these various settings over the next five years. A general estimate suggests a capital expenditure of \$700,000 and an increased annual operating cost of approximately \$665,000.

I take it that that is an estimate, Mr. Chairman, and from the remarks of the Minister of Health that he thinks that is an under-estimate.

C. Provision of research facilities.

4. It is considered that major benefit will accrue if the recommended plans are undertaken. Quite apart from the humanitarian and medical benefits, considerable saving to the economy is foreseen. Earlier and more effective treatment would result in fewer admissions to hospital; increase in the salvage rate would reduce the cost of care of many long term chronic institutional cases. Many, now totally unproductive for years, could be returned to a level of self-maintenance and

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3 productivity.

4 In estimating the amount of money that was
5 entailed at present per diem rates, 221 are no longer in
6 hospital now. This means something in the neighbourhood
7 of \$20,000 saving. That has to do with reference only
8 to their maintenance cost.

9 5. The psychiatric specialists of Manitoba
10 rely on the establishment of the principle of equal bene-
11 fits and standards of care for psychiatric patients.
12 This being accepted, we believe in and support the concept
13 of a voluntary comprehensive prepaid medical service,
14 along the lines that are currently evolving in Manitoba,
15 which recognizes the need for government support and
16 protection of indigents and the families of those unemployed
17 by reason of infirmity.

18 THE CHAIRMAN: Thank you, Dr. Pincock.
19 There are certain, I suppose, rule-of-thumb figures that
20 have been publicized as to the percentage of the popula-
21 tion that it is expected may require mental treatment.
22 What is that figure, I mean can you relate it to Manitoba?

23 DR. PINCOCK: The number that at any time
24 will require treatment?

25 THE CHAIRMAN: Yes.

26 DR. PINCOCK: It is generally estimated
27 that 12% of the population at some time during their
28 lifetime will require psychiatric care.

29 THE CHAIRMAN: Do you accept that as being
30 applicable to the Province of Manitoba? That is a country-
wide figure as I understand it.

DR. PINCOCK: We feel that that should

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have been publicized as to the percentage of the popula-

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What is that figure, I mean can you relate it to Manitoba?

DR. PINCOCK: The number that at any time

all require treatment.

THE CHAIRMAN: Yes.

DR. PINCOCK: It is generally estimated

that 1% of the population at some time during their

lifetime will require treatment.

THE CHAIRMAN: Do you accept that as being

applicable to the Province of Manitoba? That is a country-

wide figure as I understand it.

DR. PINCOCK: We feel that that should



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4 apply as it is a mere estimate, but it is based to some
5 extent on experience in countries in North America. It
6 is felt that between 40 and 50% of our patients that go
7 to doctors generally, specialists, or general practitioners,
8 are suffering from some psychiatric disorder. The majority
9 of them, of course, are neurotic psychosomatic cases.

10 But I referred to the number of beds, which is 6 per
11 thousand of population, that have been up to date used.
12 That is utilized as the standard of care necessary according
13 to the American and Canadian Psychiatric Associations.

14 THE CHAIRMAN: Also, here it is said in
15 Canada as of today that out of two patients occupying a
16 hospital bed, one is a mental patient.

17 DR. PINCOCK: Yes, there are somewhere in
18 the neighbourhood of, last year there were 75,000 patients
19 in Canada.

20 THE CHAIRMAN: Does that apply in Manitoba
21 as well?

22 DR. PINCOCK: Yes, the same figure would
23 apply in Manitoba. Our number of beds for a 100,000
24 population is a little more than the average for Canada,
25 450 beds for a 100,000 population.

26 THE CHAIRMAN: It is obvious from the
27 figures that we heard yesterday, that it costs much less
28 to maintain a mental patient per day in the hospital than
29 an ordinary patient in the run of the general hospitals?

30 DR. PINCOCK: Well, that is so, but we
feel that that is something that should be corrected. I
don't mean to imply that they should cost as much as
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THE CHAIRMAN: Also, here it is said in Canada as of today that out of two patients occupying a hospital bed, one is a mental patient.

DR. PINCOCK: Yes, there are somewhere in the neighbourhood of, last year there were 10,000 patients

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5 care that they are entitled to, and that we feel would
6 be productive of an increase in our discharge rate and
7 rehabilitation program. We are somewhere in the neigh-
8 bourhood of \$4, as compared with \$20 or more in general
9 hospitals, and over the past 40 years that I have been
10 connected myself with this service in Manitoba, the super-
11 intendants have had to walk a tightrope as between giving
12 good service to the patient and keeping up with modern
13 concepts of treatment, and maintaining good public
14 relations, decreasing the death rate in our hospitals in
15 spite of an increase in population, and come out at the
16 end of the year with a per capita per diem rate which is
17 below the average of Canada. That is about the position
18 we have been in for 40 years, and we think that is to the
19 disadvantage of the patients.

20 COMMISSIONER VAN WART: You stated that
21 through the use of modern drugs and treatment you have
22 been able to lessen the inmates in your mental hospitals.
23 Now, when these patients are discharged from the hospi-
24 tals, they are maintained on the drugs for some period of
25 time, and these drugs are quite expensive, and many of
26 the patients haven't the means to pay for these drugs.
27 How do they get these drugs in Manitoba?

28 DR. PINCOCK: Well, we have our patients
29 come back to our hospitals in the public mental hospitals
30 they come back as out-patients, and we prescribe these
drugs for them, and they are provided through the hospi-
tals who have pharmacies at a minimum cost, perhaps cost
plus a 10% over-charge, and if the patient cannot afford



have not been given the adequate care and personalized care that they are entitled to, and that we feel would be productive of an increase in our discharge rate and rehabilitation program. We are somewhere in the neighborhood of \$4, as compared with \$20 or more in general hospitals, and over the past 40 years that I have been connected myself with this service in Manitoba, the superintendents have had to walk a tightrope as between giving good service to the patient and keeping up with modern concepts of treatment, and maintaining good public relations, decreasing the death rate in our hospitals in spite of an increase in population, and come out at the end of the year with a per capita per diem rate which is below the average of Canada. That is about the position we have been in for 40 years, and we think that is to the disadvantage of the patients.

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3 to pay we write a no-charge on the prescription and the
4 patient is given the drugs.

5 COMMISSIONER GIRARD: You mentioned a
6 scarcity of personnel in psychiatry. Is there a scarcity
7 of graduate nurses working in psychiatric units? Are
8 there enough graduate nurses taking specialty in psychia-
9 tric nursing?

10 DR. PINCOCK: I would say no.

11 COMMISSIONER GIRARD: But do you have
12 enough graduate nurses not specialized in psychiatric
13 nursing, but graduate nurses?

14 DR. PINCOCK: No, we could do with more
15 of them. We would want to train those graduate nurses
16 in psychiatric nursing.

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4 COMMISSIONER GIRARD: Are there facilities
5 for training graduate nurses in the specialty of psychia-
6 tric nursing?

7 DR. PINCOCK: Yes, we have had training
8 schools in both major hospitals. We have particularly
9 one at the Brandon Mental Hospital that has been running
10 post-graduate training for nurses for many years, and the
11 number of applicants for that training goes up and down
12 with conditions in the profession generally. During
13 depression years we had a large number of girls who were
14 willing to come in and be trained simply because they
15 were out of employment -- private nurses and public
16 health nurses who were disbanding from the service. We
17 had at one time 20 at one fell swoop who came in for
18 training, but we do advertise and carry on a post-graduate
19 training for graduate nurses in psychiatry.

20 COMMISSIONER GIRARD: How long is this
21 post-graduate training for graduate nurses?

22 DR. PINCOCK: One year.

23 COMMISSIONER GIRARD: Tell me, is affilia-
24 tion in psychiatry compulsory for the student nurses in
25 the schools of nursing in Manitoba?

26 DR. PINCOCK: No, not completely. Certain
27 hospitals do insist that their nurses get not only
28 lectures but they get experience on the wards of psychia-
29 tric hospitals.

30 COMMISSIONER GIRARD: But affiliation is
not compulsory?

DR. PINCOCK: It is not compulsory.

COMMISSIONER GIRARD: Because this is one



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COMMISSIONER GIRARD: And affiliation is

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COMMISSIONER GIRARD: Because this is one



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3 way of getting student nurses in contact with psychiatric
4 nursing, and one way of recruiting them later on.

5 DR. PINCOCK: It is. In three of our
6 hospitals in Winnipeg we have psychiatric wards where
7 student nurses are given experience, and the Winnipeg
8 General Hospital sends their nurses over for psychiatric
9 care at the Winnipeg Psychiatric Hospital.

10 COMMISSIONER GIRARD: But all schools of
11 nursing do not have psychiatric affiliation?

12 DR. PINCOCK: No.

13 COMMISSIONER GIRARD: Would you be in
14 favour of that?

15 DR. PINCOCK: I would, and I think the
16 only way to achieve that would be for the Registered
17 Nurses' Association to make it a necessary qualification
18 for their R.N. examination.

19 COMMISSIONER GIRARD: One other question:
20 if this were made compulsory do you think that your
21 psychiatric hospitals or psychiatric facilities are
22 broad enough to take in all these students?

23 DR. PINCOCK: I think we could.

24 COMMISSIONER GIRARD: Would they have
25 supervision facilities?

26 DR. PINCOCK: Yes, I don't doubt at all
27 that could be accomplished.

28 COMMISSIONER GIRARD: Thank you very much.

29 COMMISSIONER BALTZAN: Mr. Chairman, I
30 only want to say I appreciate everything that Dr. Pincock
has stated, and I have no specific questions.

THE CHAIRMAN: Dr. Pincock and your



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3 associates, I would not want you to think that coming
4 late in the day your subject is not regarded as of
5 extreme importance, and I want to say this, that we
6 regard it as of such importance that it is one of the
7 two areas we have selected for special study projects
8 undertaken by members of the staff of the University of
9 British Columbia and with Dr. McKerrick in Saskatoon
10 who is going to do a special study on the changing
11 patterns in connection with the treatment of mental ill-
12 ness. So that while we may not be devoting too much time
13 to the study here today, it is one of the areas in which
14 the Commission has authorized this special study and a
15 special research project into mental illness and the
16 treatment of it against the background that mental illness
17 is just another illness, and perhaps a way may be found
18 to incorporate the treatment of mental illness into the
19 general pattern of treatment of all physical illness.

18 DR. PINCOCK: Thank you, Mr. Chairman. We
19 appreciate the courtesy, and I am sorry that the time
20 does not permit of further questioning, and we would
21 want to say if there was any further information you would
22 desire we will be very happy to produce it.

23 THE CHAIRMAN: What I mean is that our
24 research project people will be searching out groups such
25 as yours and they will be in contact with you, and any
26 of the questions we might put now would be better put by
27 the people in charge of the study, and the full picture
28 will be developed additional to the inquiry here today.

28 DR. PINCOCK: Thank you.
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4 SUBMISSION OF THE ANAESTHETIC SECTION OF THE
5 MANITOBA MEDICAL ASSOCIATION

6 Appearances: Dr. M. Minuck
7 Dr. R.S. Lambie
8 Dr. J. McCammon
9 Dr. J.D. Culligan

10
11 --- EXHIBIT NO. 57: Brief of the Anaesthetic Section of
12 the Manitoba Medical Association.

13
14 DR. LAMBIE: Mr. Chairman, with your
15 permission we will read a summary and recommendations,
16 and on two points just elaborate on the main body of our
17 brief.

18 The Anaesthetic Section of the Manitoba
19 Medical Association welcomes this opportunity to present
20 their views to the Royal Commission on Health Care.
21 This brief contains the opinions of those physicians who
22 are members of the Anaesthetic Section of the Manitoba
23 Medical Association, and members of the Manitoba Division
24 of the Canadian Anaesthetists' Society.

25 SUMMARY AND RECOMMENDATIONS

26 The field of anaesthesia has expanded to
27 include many aspects of treatment outside of the operating
28 room. Anaesthesia in Manitoba has kept pace with this
29 general enlargement of the specialty. A major impetus
30 to this growth occurred in 1952, when the principle of
private practice on a fee-for-service basis was adopted
by the Manitoba Medical Association, the hospitals and
the public. It is therefore recommended that:

- (1) the principle of private practice
on a fee-for-service basis be maintained;



Apparatus: Dr. M. M. M. M.
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 include many aspects of treatment outside of the operating
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 the public. It is therefore recommended that:
 (1) the principle of private practice
 on a fee-for-service basis be maintained;



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4 (2) there may be no intrusion of a non-
5 medical body between the patient and the
6 anaesthetist.

7 THE CHAIRMAN: What do you mean by point
8 number 2 there?

9 DR. LAMBIE: Well, if I can refer back to
10 what Dr. Trueman and what Dr. Rabson stated, we would
11 support all the things they have said. In other words,
12 if there was any government support we would rather see ---

13 THE CHAIRMAN: But you don't mean the
14 hospital management or the Board?

15 DR. LAMBIE: No, sir. Further on we can
16 elaborate on this point a little.

17 THE CHAIRMAN: Very well.

18 DR. LAMBIE: The existing facilities and
19 methods for providing personal health services including
20 prevention, diagnosis, treatment and rehabilitation.

21 The physical facilities for the treatment
22 of patients are provided by the Manitoba Hospital Services
23 Plan and the anaesthetic services are provided only by
24 qualified physicians. Thirty-two physicians in Manitoba
25 are certified by the Royal College of Physicians and
26 Surgeons of Canada. These physicians provide complete
27 anaesthetic services on a twenty-four hour basis. The
28 vast majority of these practise in Winnipeg. Anaesthetic
29 services outside of Winnipeg are provided by graduate
30 physicians on a part-time basis.

The correlation of any new or improved
program with existing services with a view to providing
improved health services.



Forty-five percent of the population of Manitoba are 'covered' by Manitoba Medical Service.

The remaining 55% consists of people who can afford to pay for medical services, and a small percentage who cannot do so. The latter are treated free of charge.

We recommend that:

Where financial need exists, provincial funds could be used for the payment of the medical services either directly or through the payment of premiums to the Manitoba Medical Service, provided that the principle of fee-for-service is upheld and that the patient/doctor relationship is maintained.

Ideally, skilled and well-informed persons must be available on an around-the-clock basis who will engage in professional work which will include preoperative assessment, care in the operating room, postoperative care, resuscitation, diagnostic and therapeutic nerve blocks, care of the newborn, and the various aspects of medicine that are now considered to be within the scope of the modern anaesthetist, as outlined previously. With this in mind, full anaesthetic resident training is provided at several hospitals in Winnipeg. These are affiliated with the University of Manitoba Medical College. We feel that the training requirements laid down by the Royal College of Physicians and Surgeons (Canada) for specialist qualifications in anaesthesia are sound.

Openings for anaesthetists have been



Twenty-five percent of the population of

Manitoba are covered by Manitoba Medical Services.

It is suggested that the Government of Manitoba should consider the possibility of providing medical services to the population of the province which is not covered by the Manitoba Medical Services.

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3 filled in the past by the entrance of a number of non-
4 Canadians. Although this is generally true throughout
5 Canada, it is particularly true in Manitoba, because of
6 reciprocal arrangements with the General Medical Council
7 of Great Britain and Ireland. In the past few years
8 there has been a marked decrease in the number of anaes-
9 thetists coming to Manitoba from the United Kingdom and
10 Ireland as well as other countries. Not only must we
11 replace vacancies caused by death, retirement and reloca-
12 tion, but we must also fulfill the expanding requirements
13 of the province. This may be done by insuring that the
14 principle of the fee-for-service private practice of
15 anaesthesia will be maintained, with adequate remuneration
16 commensurate with other specialties. A vigorous training
17 program that will attract the trainee anaesthetist, both
18 local and non-Canadian, and will insure the postgraduate
19 training of Manitoban general practitioners can be accom-
20 plished by establishing anaesthesia as a separate Depart-
21 ment, headed by a full-time Professor.

22 It is realized that it might be difficult
23 to provide specialist anaesthetists for the remoter areas.
24 The physicians practising in these areas who are usually
25 called upon to provide these services should be encouraged
26 to take didactic courses and clinical instruction in the
27 Teaching centre. Every assistance, such as tax relief,
28 bursaries or grants, should be given to enable these
29 general practitioners to take part in these courses.
30 In addition, a program should be established whereby
anaesthetists from the teaching centre are available to
consult on specific problems and to provide instruction

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2
3 in rural areas on a regular basis.

4 The present physical facilities and the
5 future requirements for the provision of adequate health
6 services.

7 The present physical facilities are inade-
8 quate for the following reason: patients requiring
9 anaesthesia for minor surgical procedures are kept waiting
10 for long periods of time before the necessary treatment
11 is carried out. These patients may occupy a hospital
12 bed for several days. We therefore recommend:

13 That special comprehensive units be built
14 either in conjunction with existing hospi-
15 tal buildings or elsewhere in order to
16 care for these patients.

17 The methods of financing health care
18 services as presently sponsored by management, labour,
19 professional associations, insurance companies or in any
20 other manner.

21 Anaesthetic services are provided by
22 physicians engaged in private practice and paid on a fee-
23 for-service basis. The agency responsible for the payment
24 of these services may be the Manitoba Medical Service,
25 the Department of Indian Affairs, Workmen's Compensation
26 Board, private insurance companies, or the patient himself.
27 'Medicare' patients and those who attend the public wards
28 are covered free of charge. The percentage of the latter
29 may be as high as 25% in some hospitals.

30 That is the condensed version of the
brief, sir.

THE CHAIRMAN: Do any of your associates

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3 wish to add anything to what you have said?

4 DR. LAMBIE: I think Dr. McCammom would
5 like to make some comment on the number of patients not
6 charged, whether they be Medicare or something else.

7 DR. McCAMMON: If the number of cases
8 that come under the category of Medicare increases to
9 any great extent it will be difficult for us to carry on.
10 With the present arrangement with the Manitoba Medical
11 Service -- and this is not your concern directly, Mr.
12 Chairman -- but under the plan in Manitoba the Medicare
13 patient's services are paid for in the home and the
14 office, and when they require hospitalization they come
15 in as free cases, and the physician in the hospital gets
16 a free anaesthetist. In other words, the anaesthetist
17 looks after it entirely free, whereas the physicians out-
18 side do have a chance to be paid for part of the services.
19 That is the only point I want to make there.

20 THE CHAIRMAN: But that is part of the
21 Medicare contract, is it?

22 DR. McCAMMON: Yes.

23 COMMISSIONER McCUTCHEON: That is part of
24 the practice of dealing with patients in public wards?

25 DR. McCAMMON: Yes. The point I was
26 making is that it is a little tougher on those being in
27 pure hospital practice. They don't have a chance to
28 render other services, whereas other types of physicians
29 and surgeons do get paid for house and office calls,
30 although they do not get paid for them while they are in
the hospital.

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5 DR. MINUCK: I can see this was an unfor-
6 tunate choice of words, Mr. Chairman. I wish to state
7 that on behalf of my colleagues and myself.

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5 anaesthesia grew as a specialty in Manitoba following
6 the introduction of the private practice of anaesthesia
7 in 1952, that is, no more paid by the hospital, that we
8 would feel it would be a backward step if the payment
9 for anaesthetic services went back to a third party who
10 was neither the patient nor the anaesthetist rendering
11 the service. That is really what we mean by that. I
12 would also want to thank Dr. Lambie for my promotion in
13 the Department of Anaesthesia at the University of Mani-
14 toba. I am a lecturer.

15 THE CHAIRMAN: Dr. Lambie, I am interested
16 in this statement that patients requiring anaesthesia
17 for minor surgical procedures are kept waiting long
18 periods and these patients may occupy hospital beds for
19 several days. How prevalent is that?

20 DR. LAMBIE: We have been concerned
21 recently and noted that many of the beds are occupied in
22 our larger general hospitals and are not acute patients.
23 They have been there many months and we feel that the
24 acute or emergency department of a hospital is not the
25 area to take care of certain minor procedures whereby
26 normally the patient is admitted. We feel that has been
27 carried out in Montreal where special facilities are
28 available for treatment to patients where anaesthesia
29 is required but not necessarily that those patients should
30 be on in-bed position.

31 COMMISSIONER VAN WART: Are any anaesthetics
32 given at the out-patient department of hospitals?

33 DR. LAMBIE: Yes, usually those are cases



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5 out-patient basis if there were proper facilities
6 available.

7 COMMISSIONER VAN WART: Patients such as
8 ear drums and so on, are they done in the out-patients'
9 or are they admitted as in-patients?

10 DR. LAMBIE: That depends on the condition.

11 DR. MINUCK: Strictly speaking these
12 patients receive - some of these patients receive anaes-
13 thetics in the emergency wards of the hospitals rather
14 than the out-patient department where the out-patient
15 department refers to the area of the charity patient who
16 is seen there and requires anaesthetic for medical-
17 surgical procedures such as teeth extractions, reduction
18 of fractures, perhaps even a simple diagnostic procedure.
19 Those are the sort of patients who could be given anaes-
20 thetics on an out-patient basis, those are patients who
21 sometimes have to wait many days or weeks to get into the
22 hospital. Once they go into the hospital they have the
23 operation and on the out-patient we feel facilities are
24 available and we could save three hospital days per
25 patient in a significant number of cases.

26 COMMISSIONER McCUTCHEON: Getting back
27 to the question of the third party, does the patient in
28 fact in very many cases select the anaesthetist or is it
29 the surgeon or the general practitioner, as the case may
30 be?

DR. LAMBIE: It would depend on the type
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3 Actually maybe either the surgeon or the patient. Now,
4 the majority of anaesthesia in Metropolitan Winnipeg is
5 done by our new basis where we offer 24 hours' service
6 both to surgical and obstetrical patients. If the
7 patient desires to have a certain anaesthetist then
8 arrangements are made so they will be satisfied.

9 COMMISSIONER McCUTCHEON: It is much like
10 Anaesthetists' Association of Toronto, is it?

11 DR. LAMBIE: Yes, the same.

12 COMMISSIONER McCUTCHEON: What percentage
13 of cases does the patient select the anaesthetist, in
14 your opinion? One percent?

15 DR. LAMBIE: I would not be able to say.

16 THE CHAIRMAN: I want to go back to these
17 minor surgical procedures that you were telling us about.
18 Can you give any specific instances or would you care to
19 give any or how often does it occur? What is the inci-
20 dence?

21 DR. MINUCK: Well, I may say this, that
22 we do at the St. Boniface Hospital which is an acute
23 general hospital of about 70 beds, we do roughly between
24 500 and 600 teeth extractions a year; we do approximately
25 600 anaesthetics in our emergency ward for minor surgical
26 procedures which would mean out of a total workload at
27 the St. Boniface Hospital of approximately 13,000 cases,
28 1,000 to 1,200, an intelligent guess would be around 10%.
29 The workload could be done for patients on an out-patient
30 basis.

THE CHAIRMAN: How much is done now?

DR. MINUCK: 5%. It is approximately 600



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3 cases we do in the emergency department now.

4 THE CHAIRMAN: You could double it if you
5 had other facilities?

6 DR. MINUCK: If we had other facilities
7 we could double it.

8 COMMISSIONER FIRESTONE: And if you
9 doubled it what savings would that mean in terms of days
10 occupied in a hospital bed?

11 DR. MINUCK: I would suggest it would save
12 a minimum of a few thousand patient days - 2,000 if all
13 the teeth extractions alone at the St. Boniface Hospital -
14 say 500 at 3 days a patient, 1,500 patient days would be
the minimum figure.

15 COMMISSIONER STRACHAN: How long would
16 you allow a patient, what in your opinion is a sufficient
17 time?

18 DR. MINUCK: As an in-patient I feel he
19 must go in the day before, stay the day of the operation
20 and be discharged the following day. I guess my figures
21 are not very accurate, that only makes two days, not
three days.

22 COMMISSIONER STRACHAN: You suggest a
23 shorter time?

24 DR. MINUCK: I think under certain circum-
25 stances it could be easily made that the patient could
26 come in as an out-patient in the morning for his teeth
27 extraction and provided that everything went well and
28 there was no unusual complication that he might go home
29 in the afternoon provided that there was no medical
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3 THE CHAIRMAN: And he would not occupy a
4 hospital bed at all?

5 DR. MINUCK: No.

6 COMMISSIONER FIRESTONE: And there would
7 be other cases as well as dental extractions?

8 DR. MINUCK: Yes, sir.

9 COMMISSIONER FIRESTONE: The figure of
10 1,500 may be an estimate on the low side.

11 COMMISSIONER STRACHAN: In general are not
12 patients put in hospital for teeth so they will be
13 attended to, there are others who could look after them?

14 DR. MINUCK: I really do not believe any
15 of the facilities for the proper predental assessment or
16 preparation and watching of the patient or for doing the
17 total extraction under general anaesthetic or for watching
18 the patient in the immediate post-operative period are
19 available in dental offices or anywhere else outside of
20 a properly built hospital unit such as we suggest.

21 COMMISSIONER GIRARD: You said a few
22 minutes ago that more anaesthetic could be given in the
23 out-patient departments if, and you qualified your state-
24 ment, if proper facilities were available. What would
25 you consider proper facilities on an out-patient depart-
26 ment would be?

27 DR. MINUCK: I understand that you are
28 referring to the out-patient department?

29 COMMISSIONER GIRARD: In a general hospi-
30 tal.

DR. MINUCK: In the same sense I was trying
to use it in the emergency ward of the hospital. What



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4 we have in mind is an expansion of this unit so that the
5 patient on entry into this particular unit may be part of
6 the hospital as it is built now and an additional unit
7 built to it will have nursing facilities so that they
8 can be taken to the area and undressed. There would be
9 laboratory facilities for certain minimal laboratory
10 tests, urinology, haemoglobin. There would be an interne
11 staffing or a physician staffing this if the unit is
12 built away from the hospital. We will suppose this is
13 in an acute ward of a hospital; then the interne will do
14 a history and a physical examination of the patient so
15 when the anaesthetist comes down to meet the patient and
16 to see him he may peruse these records, look at the labora-
17 tory findings and decide on whether the patient is
18 suitable for the anaesthetic. Then the operating room
19 facilities must be provided with the facilities of an
20 operating room and another area close by this operating
21 room, a reception unit to be used as a recovery room
22 staffed by nurses, once again, and supervised by an anaes-
23 thetist until the patient is ready for discharge. That
24 is my concept of the proper facilities.

25
26 COMMISSIONER GIRARD: You really mean in-
27 patient facilities for out-patient departments?

28 DR. MINUCK: Yes, that is right.

29
30 COMMISSIONER BALTZAN: Reference is already
made to the point I was going to raise so it will be very
short. You speak of the major growth of members occurring
in 1952 when the principle of private practice on a fee-
for-service basis was adopted. You stress that as a
major element for this increase in numbers. My question

we have in mind is an expansion of this unit so that the patient in every part of this particular unit may be part of the hospital as it is built now and an additional unit built to it will have nursing facilities so that they can be taken to the area and addressed. There would be laboratory facilities for certain animal laboratory tests, urinalysis, haematology. There would be an intern staffed or a physician staffing this if the unit is built away from the hospital. We will suppose this is in an acute ward of a hospital; then the intern will do a history and a physical examination of the patient so that the intern can see him, may peruse these records, look at the laboratory findings and decide on whether the patient is suitable for the anaesthetic. Then the operating room facilities must be provided with the facilities of an operating room and another area close by this operating room, a reception unit to be used as a recovery room staffed by nurses, once again, and supervised by an anaesthetist until the patient is ready for discharge. That is my concept of the proper facilities.

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3 is, are there any other invited factors to account, such
4 as new studies of these anaesthesiologists as we have known
5 it, and experienced in the last ten or fifteen years?
6 Also by his vital role in the management of a patient
7 during this crisis, the scientific aspect of his partici-
8 pation, etc. One just wonders how the element of the
9 fee-for-service basis alone stacks up against so many of
10 these innovations that has placed the anaesthesiologist
11 in the position where that participation in the team is
12 so inviting.

12 DR. LAMBIE: Your point is well taken.
13 It is quite true that anaesthesia as a specialty has
14 become a very interesting specialty. We mention the
15 date 1952 because previous to this they were hospital
16 employees and they received very poor remuneration. It
17 was only when they lost this employee status that they
18 became recognized. This is not actually true yet in
19 all specialties but they began to develop a specialty
20 and it is in the last decade that all the interesting
21 things have happened in anaesthesia.

21 THE CHAIRMAN: Thank you very much, Dr.
22 Lambie and your associates. We are sorry that perhaps
23 we had to keep you this long but we are trying to adhere
24 to a schedule if at all possible and we are now half-a-day
25 behind. We are going to adjourn until 9 o'clock and we
26 will proceed with the College of Physicians and Surgeons
27 of Manitoba and then carry on with our agenda.

28 --- Adjournment.
29
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to a schedule if at all possible and we are now half-a-day
behind. We are going to adjourn until 9 o'clock and we
will proceed with the College of Physicians and Surgeons

